U.S. Department of Justice
Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

January 15, 2009

Mr. Stephen Nodine
President
Mobile County Commission
205 Government Street
Mobile, AL 36644

Sam Cochran
Sheriff
Mobile County
510 South Royal Street
Mobile, AL 36601

Re: Mobile County Metro Jail

Dear Mr. Nodine and Sheriff Cochran:

We write to report the findings of the investigation of the Civil Rights Division into conditions at the Mobile County Metro Jail ("MCMJ"). On March 12, 2003, we notified officials of Mobile County ("County") and the Mobile County Sheriff's Office ("Sheriff") of our intent to conduct an investigation of MCMJ pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. As we noted, CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of inmates in adult detention and correctional facilities.

On May 27-30, 2003, and July 6-7, 2003, and again on September 22-25, 2003, we conducted on-site inspection tours with expert consultants in the fields of corrections, custodial medical and mental health care, and safety and sanitation. We interviewed administrative and security staff, medical and mental health care providers, and inmates. We reviewed an extensive number of documents, including policies and procedures, incident reports, grievances, medical records, and use of force records.

In keeping with our pledge of transparency and to provide technical assistance where appropriate, our expert consultants conveyed their preliminary impressions and concerns to the County and the Sheriff.

As you are aware, at the conclusion of our tours, the County and the Sheriff approached us to begin negotiating a means to correct the deficiencies present at MCMJ as identified by our expert consultants. Although we would not normally engage in negotiations prior to the issuance of our statutorily-required written findings, we found the desire of the County and the Sheriff to correct the deficiencies at MCMJ sincere enough to warrant our accommodation, and we immediately began negotiations while continuing our investigation and preparing our written findings. During these negotiations, we contacted the County and the Sheriff in 2006 to request cooperation in conducting a fourth tour of MCMJ to update and inform our factual findings. In continuing our pledge of transparency and to provide technical assistance, we also provided, at that time, copies of the written reports prepared by our consultants that identified deficiencies at MCMJ and recommendations on how to correct the identified deficiencies.

It was while negotiating mutually agreeable terms and conditions of our tour that the County and the Sheriff took the extraordinary and unexpected step of ceasing all communications with the Department of Justice regarding this investigation. Accordingly, and as we advised you after each of our attempts to reinitiate communications throughout 2007, we were forced to continue our investigation absent your cooperation. Specifically, since that time, we have examined state and federal survey information, media reports, and other publicly available data, as well as conducted interviews of former inmates, family and friends of inmates, attorneys, advocates, and other persons familiar with present conditions at MCMJ. In addition, as warned, we considered the failure of the County and the Sheriff to cooperate with our investigation as an adverse factor when preparing our written findings.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 U.S.C. § 1997b. We conclude that certain conditions at MCMJ violate the constitutional rights of the inmates confined there. As detailed below, we find that MCMJ engages in a pattern or practice of subjecting inmates to egregious or flagrant conditions, specifically in regard to: (1) the medical care of

inmates; (2) the mental health care of inmates; (3) the use of restraints; (4) the right of inmates to be protected from physical harm from other inmates; and (5) the right of inmates to be confined in sanitary and safe conditions.

I. BACKGROUND

The MCMJ is operated by the Sheriff of Mobile County. The Sheriff has appointed a Warden to be responsible for the day-to-day operations of MCMJ. The Sheriff employs approximately 230 corrections officers and a civilian support staff at MCMJ, as well as a medical staff which includes several nurses, a physician, and a part-time psychiatrist.

The MCMJ houses a mix of pretrial detainees and convicted prisoners ("inmates") and houses both male and female inmates. The MCMJ is comprised of two facilities - the main facility, known simply as "the Jail," and a minimum security annex, referred to as "the Barracks." The main facility ("Jail") at MCMJ was built in sections, with the first portion completed in the mid-1980s and the final sections completed in 1991. The Jail has a design capacity of 816 inmates. The Jail is constructed as a remote supervision facility, in which staff work in control areas observing inmates housed in ten semi-circular "pods." Eight pods house male inmates, and two pods house female inmates. The eight pods housing male inmates are subdivided into six eight-cell "wedges," designed to house 16 inmates in each wedge. The two pods housing female inmates are subdivided into two twelve-cell wedges. For male inmates, two wedges are designated for administrative segregation; two wedges are designated for protective custody; one wedge is designated for medical housing; and one wedge is designated for potentially suicidal inmates. The Jail also has a medical clinic and a booking area with holding cells for recent arrestees.

The MCMJ's minimum security annex ("the Barracks"), is located across the street from the Jail. The Barracks opened in September 2002, with a design capacity of 325 inmates. The Barracks contains eight dormitory-style housing units that resemble military barracks.

The population of the Jail steadily remained at approximately 1,000 inmates during 2007, while the Barracks averaged close to 300 inmates. Prior to 2007, the population in the Barracks had been significantly below design capacity. For example, at the time of our first tour in May 2003, there were only 113 inmates in the Barracks. By contrast, the Jail has frequently exceeded design capacity. For example, in the six

months prior to our first tour in May 2003, the average daily population for each month was over 1300 inmates for the Jail and Barracks combined.

II. LEGAL STANDARDS

CRIPA authorizes the Attorney General to investigate and, when necessary, initiate civil action to obtain appropriate relief from egregious jail conditions that subject inmates to a pattern or practice of deprivation of their constitutionally protected rights. 42 U.S.C. § 1997. The Eighth Amendment affords convicted prisoners protection from cruel and unusual punishment. U.S. Const. amend. VIII. This protection is incorporated into the Due Process Clause of the Fourteenth Amendment and binding upon the states. Robinson v. California, 370 U.S. 660, 667 (1962). Moreover, the Due Process Clause of the Fourteenth Amendment affords at least the same Eighth Amendment protection from cruel and unusual punishment to an inmate of a jail incarcerated prior to trial, as it would to a convicted prisoner. City of Revere v. Massachusetts Gen. Hosp., 463 U.S. 239, 244 (1983). As defined by the Supreme Court, this constitutional protection from cruel and unusual punishment requires corrections officials to provide "humane conditions" of confinement to jail inmates. Farmer v. Brennan, 511 U.S. 825, 832 (1994).

When a jurisdiction takes a person into custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being. County of Sacramento v. Lewis, 523 U.S. 833, 851 (1998) (citing DeShaney v. Winnebago County Dept. of Social Servs., 489 U.S. 189, 199-200 (1989)).

The duties imposed and rights conferred by the Eighth Amendment apply to the unreasonable risk of serious harm, even if such harm has not yet occurred:

> We have great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate's current health problems but may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year . . . . That the Eighth Amendment protects against future harm to inmates is not a novel proposition. The Amendment, as we have said, requires that inmates be furnished with the basic human needs, one of which is reasonable safety.

Helling v. McKinney, 509 U.S. 25, 33 (1993) (internal citations and quotations omitted).

A. Medical Care

A corrections official's "deliberate indifference" to an inmate's serious medical needs is a violation of the Eighth Amendment. Estelle v. Gamble, 429 U.S. 97, 104 (1976); Farrow v. West, 320 F.3d 1235, 1243-46 (11th Cir. 2003); Steele v. Shah, 87 F.3d 1266, 1269 (11th Cir. 1996). Corrections officials act with deliberate indifference when an inmate needs serious medical care and the officials fail to, or refuse to, obtain or provide that care. Farrow, 320 F.3d at 1246. Said another way, a corrections official will violate the protections of the Eighth Amendment when the official "knows of and disregards an excessive risk of inmate health." Farmer, 511 U.S. at 837. The corrections official must "both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." Id. Providing only cursory care is insufficient when the need for more serious treatment is obvious. McElligott v. Foley, 182 F.3d 1248, 1255 (11th Cir. 1999).

B. Mental Health Care

The constitutional requirement imposed on corrections officials to provide adequate medical care includes a duty to provide adequate mental health care. Farmer, 511 U.S. at 832; see also Campbell v. Sikes, 169 F.3d 1353, 1362 (11th Cir. 1999) ("proper medical care" in question consisted of mental health care provided by defendant corrections psychiatrist); Steele, 87 F.3d at 1269 (same). Delay in providing hospitalization to a prisoner in need of immediate psychiatric care may constitute deliberate indifference. See e.g., Gibson v. County of Washoe, Nev., 290 F.3d 1175, 1190-91 (9th Cir. 2002).

Furthermore, corrections officials have a constitutional obligation to act when there is a strong likelihood that an inmate will engage in self-injurious behavior, including suicide. Snow ex rel. Snow v. City of Citronelle, AL, 420 F.3d 1262, 1268-69 (11th Cir. 2005). In corrections suicide cases alleging constitutional violations, "the plaintiff must show that the jail official displayed 'deliberate indifference' to the prisoner's taking of his own life." Cook ex. rel. Tessier v. Sheriff of Monroe County, 402 F.3d 1092, 1115 (11th Cir. 2005) (quoting Cagle v. Sutherland, 334 F.3d 980, 986 (11th Cir. 2003)). In order to establish 'deliberate indifference' in a corrections suicide case, the plaintiff must demonstrate: "(1) subjective

knowledge of a risk of serious harm; (2) disregard for that risk; (3) by conduct that is more than mere negligence." Cook, 402 F.3d at 1115 (quoting Cagle at 986).

C. Use of Restraints

The Eighth Amendment protection from cruel and unusual punishment forbids the use of excessive physical force against inmates. Hudson v. McMillian, 503 U.S. 1, 5 (1992); Skrtich v. Thornton, 280 F.3d 1295, 1301 (11th Cir. 2002). The use of mechanical restraints is a type of physical force, and the initial decision to employ such restraints is evaluated under Eighth Amendment standards. See Williams v. Burton, 943 F.2d 1572, 1575 (11th Cir. 1991) (initial decision to place inmate into four-point restraints evaluated under Eighth Amendment use-of-excessive-force standards). The use of force by a corrections officer will violate the Constitution when it is not applied "in a good-faith effort to maintain or restore discipline," but instead is administered "maliciously and sadistically to cause harm." Hudson, 503 U.S. at 6-7; Campbell, 169 F.3d 1353, 1374 (11th Cir. 1999); Harris v. Chapman, 97 F.3d 499, 505 (11th Cir. 1996); Williams, 943 F.2d at 1575. Courts may examine a variety of factors in determining whether the force used was excessive, most commonly including: (1) the need for the application of force; (2) the relationship between the need for force and the amount of force applied; (3) the threat, if any, reasonably perceived by responsible corrections officers; and, (4) any efforts made to temper the severity of a forceful response. Hudson, 503 U.S. at 7-8; Campbell, 169 F.3d at 1375; Harris, 97 F.3d at 505; Williams, 943 F.2d at 1575. Additionally, courts will also factor into the analysis the extent of the inmate's injury at the hands of the corrections officers. Id.

Further, "once the necessity for the application of force ceases, any continued use of harmful force can be a violation of the Eighth and Fourteenth Amendments, and any abuse directed at the prisoner after he terminates his resistance to authority is an Eighth Amendment violation." Williams, 943 F.2d at 1576 (citing Ort v. White, 813 F.2d 318, 324 (11th Cir. 1987)). In addition to the Eighth Amendment standards applicable to the use of restraints, Fourteenth Amendment procedural due process considerations must be accounted for when the restraint is employed as punishment, defined as "a penalty administered after reflection and evaluation and intended to deter similar conduct in the future," distinct from restraints employed as immediately necessary "to bring an end to an ongoing violation." Id.

D. Security, Supervision, and Protection From Harm

The Supreme Court in Farmer made clear that inmates have a constitutional right to be protected from harm. Farmer, 511 U.S. at 832. Accordingly, corrections officials have a duty "to protect prisoners from violence at the hands of other prisoners." Farmer, 511 U.S. at 833 (internal quotation marks and citations omitted). Not every injury suffered by an inmate at the hands of another inmate, however, will constitute an Eighth Amendment violation. The inmate invoking the right must demonstrate that (1) he or she was "incarcerated under conditions posing a substantial risk of serious harm," and (2) that corrections officials were "deliberately indifferent" to the risk. Farmer, 511 U.S. at 834. A corrections official's failure to supervise inmates, particularly inmates known to be violent, may result in unconstitutional conditions of confinement where assaults between inmates occur due to the lack of supervision. Cottone v. Jenne, 326 F.3d 1352, 1360 (11th Cir. 2003).

E. Safety and Sanitation

The Eighth Amendment guarantees that prisoners will not be "deprive[d] . . . of the minimal civilized measure of life's necessities." Rhodes v. Chapman, 452 U.S. 337, 347 (1981). Accordingly, corrections officials are required to provide "reasonably adequate ventilation, sanitation, bedding, hygienic materials, and utilities (e.g., hot and cold water, light, heat, plumbing)." Chandler v. Baird, 926 F.2d 1057, 1065 (11th Cir. 1991) (citations omitted). Conditions will violate the Constitution when they pose an unreasonable risk of serious damage to an inmate's current or future health, and the risk is so grave that it offends contemporary standards of decency to expose anyone unwillingly to that risk. Helling v. McKinney, 509 U.S. 25, 33-35 (1993); Chandler v. Crosby, 379 F.3d 1278, 1289 (11th Cir. 2004).

III. FINDINGS

A. Medical Care

Our investigation revealed constitutional inadequacies in the level of care provided by MCMJ in responding to inmates' serious medical needs. In 2007, we shared with the County and the Sheriff the written findings and concerns of our expert medical consultant regarding the inadequate medical care at MCMJ. Information we have obtained since that time, however, strongly suggests that MCMJ has done little to correct the identified deficiencies.

Specifically, we found that MCMJ failed to provide adequate acute care, chronic care, treatment of infectious diseases, intake screening, and general access to medical care. As explained below, such deficiencies primarily result from inadequate staffing, lack of proper supervision, and the lack of adequate written medical policies and protocols.

1. Acute Care

At the time of our tour in September 2003, MCMJ had failed to provide timely and appropriate responses to the acute medical needs of inmates. Three inmate deaths that occurred near that time exemplify these failures. Our expert medical consultant reviewed the medical circumstances surrounding the three inmate deaths and concluded that the lack of timely and appropriate response to the inmates' acute medical needs may have contributed to their deaths. For instance:

- In June 2002, an inmate complained of fever, shakes, and acute pain in her leg and foot. This inmate was not evaluated by a MCMJ physician. A licensed practical nurse examined her and found swelling, bruising, and sores. Generally accepted corrections medical practices call for a physician to evaluate any acute onset of leg pain to evaluate for blood clots or deep infection, which can pose a serious risk of harm. Instead, this inmate received an antibiotic and Motrin[1] by telephone order from the physician. Although MCMJ reports that this inmate was transported to the hospital at this time and then returned to MCMJ, there were no records of the hospital visit in the inmate's medical record. The next day, her leg was tender and warm, and she was so sick that she was incontinent of feces. She then went into cardiac arrest, MCMJ staff performed CPR, and she was transported to the hospital, where she died soon thereafter. This inmate's deep vein thrombosis was not timely recognized or treated.

- Another inmate upon arrival at MCMJ in December 2002 reported a history of high blood pressure and hepatitis C. The inmate was not evaluated or treated by a physician. Six days later, corrections staff took him to see the nurse because he was disoriented, shaking, and incoherent, which are signs of a

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[1] "Motrin" is a brand name for the anti-inflammatory medication ibuprofen.

life-threatening emergency requiring immediate care. He did not receive immediate care, but instead the licensed practical nurse placed his name on the list to see a psychiatrist and sent him back to his unit. The next day corrections staff again took the inmate to the nurse after he was observed vomiting blood. He remained disoriented and had substantially elevated blood pressure. The nurse placed his name on the list to see the physician during regular sick call, six hours later. She left him alone for 90 minutes, and when she returned to the clinic she sent him to the hospital emergency room. The inmate died in the hospital. Timely medical treatment may have prevented this death.

- In August 2003, an inmate arrived at MCMJ with an acute trauma to his left eye and a paralysis of the right side of his face. He reportedly refused to see the physician, although his chart contained no signed refusal and no documentation of any attempt to convince him to agree to medical care. Even if the inmate refused medical care at intake, he should have been housed in the infirmary and observed. Instead, this inmate was placed in the general population. Five days later, when he requested medical care, his left eye was dilated, his speech slurred, and he was unable to walk. His condition had deteriorated to such an extent that he was sent to the hospital, where he was diagnosed with a heart valve infection – which could have caused his facial paralysis – congestive heart failure, and sepsis (infection of the blood). He died before he could receive surgery to replace his heart valve. If this inmate had received treatment several days earlier, his chance of survival would have been much higher.

Since our September 2003 tour, we have learned of at least six more in-custody deaths at MCMJ. In three of those cases, it is alleged that MCMJ's poor response to the inmates' serious acute medical needs contributed to the inmates' deaths.[2] We have requested the opportunity to examine the medical circumstances surrounding those deaths, but the County and the Sheriff have denied our request.

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[2] We are equally concerned about the other three cases which are reportedly suicides, and discussed in section III.B.4 of this letter.

Furthermore, since our 2003 tour, we have learned of allegations regarding the MCMJ's inadequate treatment of serious injuries suffered by inmates while incarcerated at MCMJ. For example, in July 2005, an MCMJ inmate reportedly suffered serious spine and neck injuries after a fall during a work-shift. It is alleged that after waiting an hour to receive emergency medical treatment, the inmate was given aspirin to relieve his pain. Reportedly, no other treatment was provided, and no further medical appointments were scheduled, despite the inmate's request to see a physician. Allegedly, after several weeks, the inmate's condition worsened as he began to lose weight, become frail and non-ambulatory. By the time the inmate eventually saw a physician in a hospital, it is reported that his injuries had already begun to heal improperly and the inmate suffered permanent damage to his spine and neck.

We found that MCMJ's problems in providing acute medical care were caused or exacerbated by inadequate protocols, supervision, and training. The protocols for nurses did not provide adequate guidance regarding treatment of inmates who exhibited common acute symptoms. In addition, nurses did not receive training in taking medical history or in conducting physical assessments. Thus, the nurses had no guidance on when it was appropriate to seek a higher level of care from a physician.

2. Chronic Care

Generally accepted corrections medical practices require inmates with chronic conditions to receive ongoing, coordinated care and monitoring to prevent or minimize the progression of their diseases. After completing our 2003 tour, we concluded that MCMJ failed to identify and treat adequately inmates with chronic conditions such as asthma, diabetes, hypertension and HIV. The MCMJ did not separately track inmates with chronic diseases as required by generally accepted corrections medical practices. We therefore had to review medication administration records to attempt to identify inmates with chronic conditions. We found the number of inmates being treated for diabetes, hypertension, and asthma to be one-third of what is expected for jails in the United States.[3] This finding indicates that MCMJ was likely failing to identify inmates with chronic diseases,

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[3] National Commission on Correctional Health Care, Health Status of Soon-to-Be-Released Inmates, http://www.ncchc.org/pubs/pubs_stbr.html (last visited September 2, 2008).

which probably stemmed from an inadequate screening and assessment process discussed in further detail in section III.A.4 of this letter.

Chronic conditions are progressive, and require proper monitoring and treatment to prevent conditions associated with end-stage organ failure, such as blindness, heart disease, kidney failure, and lung disease. For example, generally accepted corrections medical practices require that asthmatic inmates receive peak flow monitoring to measure the volume of air flowing out of the lungs, which can reveal narrowing of the airways well in advance of an asthma attack. This monitoring should be done on a quarterly basis, or more frequently if the inmate is short of breath. However, at the time our tour, MCMJ did not conduct peak flow monitoring unless inmates provided their own peak flow meters.

Similarly, diabetic inmates did not receive simple laboratory tests of their insulin levels to monitor their status. As the example below illustrates, we found the monitoring of inmates with chronic conditions at MCMJ to be deficient.

- In August 2003, an inmate with diabetes reported a sudden onset of blurry vision, which indicates potential acute retinal disease that can lead to blindness without prompt evaluation and treatment. This inmate did not receive an adequate eye examination and had not been referred to an ophthalmologist at the time of our third tour, over one month later.

Several recent allegations regarding diabetic inmates suggest that the chronic care deficiencies present at MCMJ at the time our tour remain. For example, in 2005, an inmate who was Type I diabetic alleged that she made repeated requests for insulin and glucose tests. Corrections officers reportedly assumed that the inmate was "detoxing" from a drug addiction and denied all of the inmate's requests for medical attention, despite the inmate's insistence that she was not a drug-addict. After several days without insulin, the inmate's condition allegedly worsened to a life-threatening level. Reportedly, the medical staff at MCMJ transferred her to a local hospital and the inmate spent the next six days in the hospital, the first four days of which she remained in the intensive care unit.

Moreover, at the time our tour, MCMJ did not stock the basic medications necessary to treat chronic diseases such as asthma, diabetes, hypertension, major depression, and schizophrenia. As a result, inmates with chronic diseases routinely waited three to

five days from prescription to the administration of the first dose of medication. Such a period of time is unacceptably long in light of the severity of the issues. Other inmates with

chronic diseases waited longer to receive their medications, and some never received prescribed medications at all. For example:

- During one of our tours in 2003, an inmate was exhibiting severe respiratory compromise from acute and chronic asthma. Although she had been prescribed prednisone, a steroid that would reduce the inflamation in her lungs and allow her to breathe, she had not received the medication. Without prednisone, she was at risk of developing respiratory failure.

3. Infectious Diseases

We found that MCMJ did not adequately identify or treat infectious disease. Failure to adequately identify and treat infectious disease places inmates, staff, and the community at unnecessary risk of serious health problems. Our review of MCMJ records indicated MCMJ ordered purified protein derivative ("PPD") skin tests, which test for tuberculosis, for only about half of the inmates, and documented test results for less than 10 percent of inmates. Similarly, we found syphilis screening results in less than 10 percent of inmate records. Both PPD tests and syphilis screening are required by MCMJ policy and by generally accepted corrections medical practices. Furthermore, MCMJ has inadequate policies in place to recognize and prevent the transmission of blood-borne (e.g., HIV and viral hepatitis) and air-borne (e.g., tuberculosis) pathogens. For example, the policies failed to address post-exposure protocols for blood exposures, maintenance of respiratory isolation, and vaccination against Hepatitis B.

During our September 2003 tour, we concluded that MCMJ failed to treat properly inmates with tuberculosis. For example:

- We identified at least three inmates who were receiving a particular antitubercular medication - Rifampin - alone, a medication that should never be used without other antitubercular medications. Using Rifampin alone can result in the development of drug resistance, which not only threatens the health of the inmate, but also poses a serious public health danger.

- An inmate who had HIV was clearly receiving Rifampin in error. His prescription was written for Rifabutin, a medication used in late stage HIV; instead, he received Rifampin.

- The MCMJ also apparently failed properly to isolate inmates with potentially contagious tuberculosis. An inmate with suspected tuberculosis was housed in a reported negative pressure room, which is designed to contain contagious tuberculosis. Consistent with generally accepted corrections medical practices, such rooms must be tested monthly to ensure proper functioning. However, the room did not appear to be in operation and the health services administrator was not aware if the room had ever been tested. Such a failure places staff and other inmates in the infirmary at risk of tuberculosis infection.

Furthermore, our expert corrections medical consultant identified a widespread skin infection, which had not been identified by MCMJ medical staff. Numerous inmates exhibited large boils on various parts of their bodies that they contracted well after reception into MCMJ, and these inmates faced long delays in treatment. The MCMJ had not conducted cultures which likely would have assisted in identifying the outbreak, and MCMJ had not contacted local health officials to provide notice of the contagious infection or to receive assistance or guidance. The skin infection was likely Staphylococcus aureus, a bacteria that can cause septicemia (blood infection), myocarditis (heart valve infection), infections of the tissues surrounding the brain, and death.[4]

4. Intake and Initial Assessment

When we evaluated MCMJ's intake process and initial medical assessments in 2003, we found that MCMJ failed to identify inmates with serious medical needs and thus put inmates at an unreasonable risk of harm. At MCMJ, corrections officers

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[4] We note that at the Sheriff's request, we have provided technical assistance to MCMJ regarding the skin infections. We understand that MCMJ was working with the Mobile County Department of Health to address this outbreak. The MCMJ reports taking several measures to address this outbreak, including purchasing new laundry machines and cleaning inmate-occupied areas. The MCMJ did not, however, provide the Department of Justice information regarding the final status of the outbreak.

conducted intake screening as each inmate was received. However, the officers received no training concerning health screening, and many serious medical issues were ignored at intake. For example, the Jail Receiving Screening Form utilized by corrections officers failed to collect the following basic information: all current illnesses, past serious infectious disease, recent symptoms of infectious diseases, past mental illness, legal or illegal drug use, and specific drug withdrawal symptoms.

The MCMJ policy required a nurse to perform a supplemental medical history within 72 hours of each inmate's intake. For more than half of the current and recently-released inmates whose files we reviewed, MCMJ failed to comply with this policy, even for inmates with very serious medical needs. The health services coordinator confirmed that the medical clinic was not adequately staffed to review each inmate within 72 hours, and estimated that 30 to 35 percent of inmates are not seen within 72 hours of admission. Even if MCMJ complied with its own policy, 72 hours is too long a delay for an assessment of inmates with acute or chronic medical needs, continuity of medication requirements, or infectious diseases. Generally accepted corrections medical practices require that inmates with acute or chronic medical conditions be seen by a nurse within four hours of intake for evaluation and referral to a physician, if necessary.

Moreover, the 72-hour supplemental nursing assessment at MCMJ was inadequate to identify inmates' serious medical needs, as the assessment consisted of nothing more than recording basic vital signs. For example:

- An inmate incarcerated in August 2003 with diabetes did not have a documented blood sugar test on intake, which placed this inmate at risk of ketoacidosis, a potentially fatal complication of diabetes.

Although MCMJ policy was consistent with generally accepted corrections medical practices by requiring a complete health assessment to be conducted within 14 days of an inmate's arrival, we noted unreasonable delays in conducting these assessments and a lack of appropriate referrals. For example, during our September 2003 tour, an inmate reported that he was incontinent of urine, but was not referred to a physician for diagnosis and treatment.

In addition, MMCJ did not properly identify and treat serious drug and alcohol intoxication and withdrawal symptoms,

placing inmates at risk of potentially life-threatening symptoms such as seizures and delirium. For example:

- In May 2003, MCMJ did not identify, evaluate, or treat an inmate at intake who was at risk of experiencing benzodiazepine withdrawal.[5] The inmate subsequently made at least seven requests for medical evaluation due to her withdrawal symptoms, but received no treatment for her potentially serious drug withdrawal.

- Another inmate, who was in restraints, apparently was suffering from alcohol withdrawal and had purple extremities, was sweating profusely, and was "jerking badly." A note in the inmate's medical file quotes the nurse as responding, "That's part of DTs and there isn't nothing we can do." Delirium tremens, a physical and mental disturbance caused by withdrawal from alcohol use after prolonged drinking - sometimes called the "DTs" - can cause serious hallucinations and potentially life-threatening seizures. By generally accepted corrections medical practices, this inmate should have received Librium, a medication helps prevent the symptoms of delirium tremens from worsening, as well as fluids, and close monitoring of his vital signs.

We have since learned that in February 2008, a MCMJ inmate died of an apparent drug overdose. The inmate was reportedly found unconscious in his cell on the same day he was arrested on drug possession charges. The MCMJ allegedly transported the inmate to the hospital where he was pronounced dead, and preliminary tests reportedly indicated the presence of drugs in his system. This recent death suggests that the problems we identified in 2003 have not been resolved, despite the fact that we provided the County and the Sheriff our expert medical consultant's written report in 2007.

5. General Access to Medical Care

At the time of our tour, MCMJ's sick call process failed to provide adequate access to medical care. The MCMJ inmates

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[5] Benzodiazepine is a medication that depresses the central nervous system and is used, for example, to treat certain seizure disorders and anxiety. Withdrawal from benzodiazepine can result in potentially life-threatening symptoms such as seizures and delirium if not appropriately treated.

accessed medical services by completing sick call requests.[6] Inmates reported making multiple requests before receiving medical care. Our review of medical files confirmed that many inmates made between two and six requests for treatment of serious medical needs before receiving care, such as the inmate in benzodiazepine withdrawal discussed above in section III.A.4. Other examples include:

- Medical staff failed to respond to three requests for care from an inmate with vaginal discharge. Failing to evaluate this inmate put her at risk of serious infection, and created a potential public health risk, as such symptoms are consistent with a venereal disease.

- In August 2003, an inmate complained he was incontinent of urine, which may be caused by an infection or a serious, but treatable, neurologic problem. There was no indication in his file that he was referred to a physician for treatment.

Additionally, at the time of our tour, MCMJ charged a $10.00 co-payment for each visit to a licensed practical nurse. The MCMJ policy also required that indigent inmates be provided free medical care and MCMJ appeared to be implementing this policy. Nevertheless, while this policy does not violate inmates' constitutional rights, we are concerned that numerous inmates told us that requests for medical care by indigent inmates are ignored. Apparently this alleged practice of ignoring the medical requests of indigent inmates is so pervasive as to result in indigent inmates not requesting medical care for serious medical needs. We flag this finding because, although not a constitutional violation, the perception that indigent inmates will not be provided medical care is a barrier to accessing such care.

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[6] Inmates submitted sick call requests to corrections staff, who delivered them to the medical unit. Allowing corrections staff to serve as gatekeepers for medical services potentially compromises timely access to medical care. We understand that the MCMJ has recently installed lock boxes for inmates to file grievances and we encourage a similar system for sick call requests.

6. Staffing

The above-noted deficiencies in acute care, chronic care, intake services, and identification and treatment of infectious diseases were likely caused or aggravated by inadequate medical staffing. At the time of our tour, MCMJ provided its 1,000 to 1,300 inmates with only 20 hours per week of physician staffing for their primary medical care needs. This is grossly insufficient to meet the acute and chronic needs of this large population, and health care provided to inmates was compromised by this significant shortage.[7] In addition, the nursing staff was inadequately supervised, which led to the deficiencies noted above in acute care, intake assessment, sick call, and medication errors.

B. Mental Health Care

Our investigation revealed that mental health services at MCMJ were grossly inadequate to meet the serious mental health needs of inmates. At the conclusion of our tours in 2003, our expert corrections mental health consultant identified specific concerns in MCMJ's delivery of mental health care. In 2007, we provided the County and the Sheriff with a written report prepared by our expert corrections mental health consultant outlining the mental health care deficiencies at MCMJ. Despite our several requests to revisit the facility and evaluate MCMJ's progress on improving the mental health care provided to its inmates, neither the County nor the Sheriff have provided us with access or any documentation to suggest that the deficiencies we identified in 2003 and 2007 have been addressed or corrected. In fact, three MCMJ inmate suicides that have occurred since 2003 strongly suggest the problems present at the time of our tour remain unresolved.

Specifically, we identified problems and deficiencies in intake screening; access to mental health care; assessment, management and treatment of mental illnesses; and suicide prevention. As explained below, such deficiencies result in part from inadequate mental health care staffing and the lack of a mental health care program, as well as inadequate policies and procedures.

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[7] In the opinion of our expert corrections medical consultant, a facility of MCMJ's size requires a minimum of 60 hours per week of physician staffing to provide adequate medical care.

1. Intake and Initial Assessment

Failure to identify and respond appropriately to inmates' serious mental health needs can lead to significant medical deterioration, and in some cases can even lead to death by suicide. We found that MCMJ's intake process failed to identify adequately inmates with serious mental health needs.

Intake screening should be used to identify inmates with histories of mental health treatment, major mental illness, and suicide potential, as well as inmates who need psychiatric medications. As discussed above in section III.A.4 of this letter, corrections officers conducted initial intake screening on incoming inmates by filling out Jail Receiving Screening Forms. The officers received no training on mental health screening. In addition, the screening forms themselves did not require officers to gather adequate mental health information; for example, the forms lack screening questions regarding major mental illness or developmental disability.

The MCMJ also failed to record consistently or respond adequately to the mental health information in the screening form. The forms were often incomplete, completely blank, lacking pertinent information such as current medications, or contained no information about an inmate's mental health status or history. Other forms contained pertinent mental health information, but medical records indicated there was no, or significantly delayed, follow-up by MCMJ staff. For instance:

- The intake screening of one inmate in May 2003 revealed that he had possible suicidal ideation, yet some four months after his intake, there was no documentation that he was ever referred for, or received, an evaluation by MCMJ mental health care staff.

- Although an inmate in August 2003 was identified as potentially suicidal at intake, the inmate did not see the psychiatrist until 10 days later.

- One inmate's custody screening in July 2003 revealed a history of past mental problems, including a history of treatment with Zyprexa, an antipsychotic. Nevertheless, she was not seen by the psychiatrist for two months, by which time her condition had worsened to the point that she had become psychotic.

As will be discussed further below, we noted similar failures to identify or respond to inmates taking psychotropic medications. Such failures delay the continuity of medications and create a serious risk of harm for inmates with psychosis and mood disorders. Left untreated due to interrupted or discontinued medications, such inmates may harm themselves or others.

The first step in providing inmates with proper mental health care is identifying and diagnosing inmates with serious mental health needs. At the time of our tour, however, MCMJ significantly under-diagnosed serious mental illnesses. Without proper diagnoses, mentally ill inmates risk receiving inadequate or inappropriate medication and treatment, or no medication or treatment at all. This can lead to psychiatric decompensation, that is, the inmate's psychiatric symptoms can worsen and lead to depression, psychosis, or other acute problems. Such inmates are often subject to heightened victimization or to violent outbursts which can impact jail staff and other inmates.

As with inmates with chronic illnesses, MCMJ should, but did not, keep lists of inmates with mental health needs. Accordingly, we had to examine medication administration records to attempt to identify inmates with psychiatric needs. At the time of our tour, national studies indicated that approximately 16 percent of male inmates and 23 percent of female inmates can be expected to have a mental illness.[8] At MCMJ, however, only six percent of male inmates were being treated with psychotropic medications, which is about one-third of the number of male

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[8] Paul M. Ditton, Bureau of Justice Statistics, Mental Health Treatment of Inmates and Probationers (1999), http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf (last visited September 2, 2008) (This study defined a "mentally ill" inmate as any inmate that "reported a current mental or emotional condition, or . . . reported an overnight stay in a mental hospital or treatment program."). We note that recent national studies illustrate a dramatic increase in population of jail inmates with mental health care needs. For example, Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates (2006), http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf (last visited September 2, 2008) reports that 75 percent of female jail inmates, and 63 percent of male jail inmates, have a mental health problem. This study defined an inmate with a "mental health problem" as any inmate that had "a recent history or symptoms of a mental health problem" within the prior 12 months.

inmates with mental illness typically found in jails in the United States. Seventeen percent of female inmates were on such medications, about two-thirds of the number of female inmates with mental illness typically found in jails in the United States. These findings indicate that many inmates in need of mental health care, particularly male inmates, likely were not identified and as a consequence did not receive necessary mental health treatment. Indeed, the problem of under-diagnosing mentally ill inmates at MCMJ is likely worse than we estimate, as our examination of the medication administration records to identify mentally ill inmates consequently excludes those mentally ill inmates who are not being treated with psychotropic medications.

This observation was corroborated by reviewing individual inmate records, which indicated widespread under-diagnosis of mental illness. For example:

- One inmate's intake screening in June 2003 did not indicate any mental illness. Although he was placed in administrative segregation for suicidal ideation the day after being taken into custody, his 72-hour nursing assessment also did not indicate any mental illnesses and he did not see the psychiatrist until after he submitted a request over two weeks later. The psychiatrist concluded the inmate had a bipolar disorder and prescribed the antipsychotic medication Zyprexia.

- Another inmate's intake assessment in June 2003 did not note any mental health care concerns, but a nursing assessment twenty days later revealed that the inmate had a history of treatment with the psychotropic medications Prozac and Ritalin. The intake assessment failed to identify this inmate's mental health care needs, and thus delayed any mental health treatment the inmate may have required.

2. Access to Mental Health Care

In September 2003, we found that MCMJ did not provide adequate access to mental health care. Inmates typically made numerous requests to see the psychiatrist, and were faced with significant delays in response to their requests. Our review of records indicated that the delays ranged from weeks to many months, even for inmates with very serious mental health needs. We also noted many instances where follow-up care ordered by MCMJ mental health staff did not occur. For example:

- An inmate with a documented diagnosis of Schizoaffective Disorder[9] and a history of treatment with four antipsychotic medications made five written requests in July 2003, to see the psychiatrist before she was seen, five weeks after her arrival at MCMJ.

- In July 2003, a nurse made a referral for an inmate to see the psychiatrist due to depression. Almost two months later, he still had not seen the psychiatrist and had become suicidal. It still took an additional three weeks for the inmate to receive an initial psychiatric evaluation.

- In April 2003, a nurse referred an inmate for a psychiatric consult as a result of the inmate's fearfulness, hyperactivity, and sleeplessness, but this inmate was not seen by the psychiatrist until three weeks after the nurse's referral. These delays are far too long, and are a substantial departure from generally accepted corrections mental health practices, especially when inmates are experiencing acute mental health symptoms. Without adequate access to mental health care, serious mental health needs may go undiagnosed and mentally ill inmates who present a risk of harm to themselves and others may be left untreated.

All of the information we have collected since our review of the records strongly suggests that this problem continues. Appropriate, timely mental health treatment is critical to regulate the symptoms of mental illness and to minimize psychiatric decompensation.

3. Assessment, Diagnosis, and Treatment

Our investigation revealed that when MCMJ identified and responded to inmates with serious mental health needs, it failed to provide adequate treatment. All aspects of the mental health care delivery system were inadequate, including assessment and diagnosis, treatment planning, and pharmacological interventions. These problems, as will be discussed below, were exacerbated by

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[9] Schizoaffective Disorder is a condition in which a person meets the criteria for both schizophrenia and a mood disorder. Such a person may experience psychosis such as hallucinations or delusions commonly associated with schizophrenia, while concurrently experiencing symptoms of depression.

inadequate psychiatric staffing. In addition, MCMJ did not provide non-psychiatric mental health care services, such as group therapy or other services provided by social workers, counselors, or other mental health care workers.[10] Providing these types of services are in accordance with generally accepted corrections mental health practices.

Additionally, many psychiatric progress notes lacked diagnoses, which are essential to determining the appropriate treatment for an inmate's mental health needs. For example:

- In May 2003, one inmate was treated with several psychotropic medications but did not have a specific psychiatric diagnosis.

- Another inmate who entered MCMJ in April 2003, had significant periods of self-injurious behavior, including head-banging and swallowing glass, but never received any psychiatric diagnosis. Nonetheless, he was treated with increasing doses of antipsychotic medications.

- Still another inmate was treated with antipsychotic medications, although he had no history of treatment for mental illness or other clear indications of the need for antipsychotic medication. Antipsycotic medications have a number of potentially serious side-effects, including tardive dyskinesia.[11] Failing to appropriately diagnose inmates with mental health needs, but treating them with psychotropic medications, is grossly inappropriate and unnecessarily places inmates at risk of harm.

Moreover, MCMJ frequently prescribed Elavil, an antidepressant medication, to address inmates' sleeping difficulties. Elavil has significant and potentially serious side effects, and can be lethal in overdose. Elavil therefore should not be used for sleep disturbances without appropriate evaluation or medical assessment.

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[10] Reportedly, MCMJ has hired a psychiatric nurse who accompanies the psychiatrist to MCMJ for six hours a week.

[11] "Tardive dyskinesia" is a potentially irreversible movement disorder characterized by repetitive involuntary movements.

Inmates also experienced serious delays in receiving psychiatric medication. For example:

- One inmate in June 2003 waited 23 days after intake, including five days after seeing the psychiatrist, before receiving two psychotherapeutic drugs, Remeron and Buspar.

- Another inmate went at least three weeks without treatment with the psychotropic medications that she had been taking when she arrived at MCMJ, and had no documented psychiatric evaluation.

Delays in the continuity of psychiatric medications pose a serious risk for mentally ill inmates, and may cause the inmate to experience psychotic decompensation or cause the inmate to harm himself or others.

We further identified inmates who received no treatment for their psychiatric needs. For instance:

- One inmate's initial assessment, which occurred three weeks after his arrival in March 2003, revealed a history of treatment with the antipsychotic medications Zyprexa and Thorazine during a recent prior incarceration at the MCMJ. Despite this recent history, five months later, when we examined his medical chart, he had not been evaluated by the psychiatrist or received psychotropic medication.

- Another inmate in July 2003 requested a psychiatric evaluation to continue his treatment for depression. At the time of our examination of this inmate's medical chart, almost three months later, the inmate had not been seen by a psychiatrist and had received no psychiatric treatment.

4. Suicide Prevention

At the time of our tour, MCMJ failed to provide adequate assessment, monitoring, and housing of suicidal inmates. Suicide is a form of mental illness constituting a serious medical need for which MCMJ must provide adequate treatment. We have learned that at least three MCMJ inmates committed suicide since our September 2003 tour. According to a recent public statement by the MCMJ Warden in the Mobile-Register, "about six inmates a year

attempt suicide, and about one a year is successful."[12] One suicide a year is approximately twice the national average for facility the size of MCMJ.[13] Thus, it would appear that MCMJ has not resolved its very serious suicide prevention problem.

All three of the recent suicides were reportedly hangings, two of which allegedly occurred with bedsheets. Two of the three suicides occurred within three months of each other. The most recent suicide was committed by a male inmate who at the time of his arrest at his home, according to police, doused himself with gasoline and threatened to set himself afire in front of his wife and children. Despite this conduct at the time of his arrest, it does not appear that the inmate was put on suicide watch at MCMJ until four days after intake. More troubling still, the inmate was reportedly removed from suicide watch by medical staff prior to his death.

As noted above, we observed unreasonable delays in providing mental health care to suicidal inmates in MCMJ. In addition, MCMJ did not assess properly the severity of an inmate's suicide risk and did not provide treatment specific to the inmate's risk of suicide. Instead, suicidal inmates were frequently asked to sign behavioral contracts promising not to harm themselves. These contracts were simply forms that state that the inmate "promise[s] not to harm myself while incarcerated at the Mobile County Jail." After an inmate signed a contract, the inmate was usually placed in the general population without any suicide precautions. These contracts are not an adequate method of preventing suicide or self-harm and appear to provide a false sense of security for staff, and an excuse not to monitor regularly inmates who sign the contracts.

Additionally, we found that MCMJ improperly monitored suicidal inmates. We specifically brought this urgent matter to the attention of MCMJ during our tour. Suicidal inmates who refuse to sign behavior contracts are housed in the medical unit or in the "suicide wedge." Although we note that corrections staff performed adequate 15-minute checks of inmates in the

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[12] Dan Murtaugh, Jail to Revamp Suicide Cells, Mobile-Register, May 30, 2007, at B1.

[13] Bureau of Justice Statistics, Deaths in Custody Statistical Tables: Local Jail Deaths 2000-2005, http://www.ojp.usdoj.gov/bjs/dcrp/tables/jailstab3.htm (last visited September 8, 2008) (average annual suicide rate for 2000 - 2005 is 45 per 100,000 local jail inmates).

suicide wedge, the physical attributes of the cells in the suicide wedge presented dangers to inmates. The cells had solid metal doors and thus their interiors, as well as inmates in the cells, were not directly visible to corrections staff. The cells had not been modified to remove sharp edges or other items that could be used for self-harm. Many cells had writing on the walls, indicating that suicidal inmates had access to writing utensils that could be used for self-harm. In addition, inmates in the suicide wedge did not receive regular and periodic evaluations by mental health staff. Some inmates who had been placed on suicide watch were never seen by a psychiatrist.

The MCMJ relied on an inmate "buddy system" to monitor suicidal inmates housed in both the medical area and in the suicide wedge as a supplement to the monitoring by corrections staff. These inmates sat with and monitored suicidal inmates. While this is an acceptable procedure, MCMJ must provide adequate monitoring, training, and select inmates who can be relied upon to perform this service. We found that MCMJ provided little or no training to these inmate workers and some showed little motivation or interest in performing their duties.

5. Policies and Procedures

The failures of MCMJ's mental health services were caused in part by MCMJ's lack of adequate policies and procedures, as well as its failure to implement some policies and procedures that appear to be adequate. A number of MCMJ policies and procedures did not address fundamental components of the topic they cover. For example, the policy regarding suicide prevention did not include instructions on how to assess suicide risk. Similarly, the policy on the use of forced psychotropic medications was silent on basic tenets of the use of forced psychotropics, such as duration of use and monitoring of the inmate. Other MCMJ policies on mental health appear adequate, yet in practice the policies were ignored. For example, the policy on chemically dependent inmates required MCMJ to refer these inmates to an outside treatment center. The actual practice revealed that numerous chemically dependent inmates were not referred for treatment; in fact, chemically dependent inmates were not properly identified, and many received no treatment from MCMJ, which is a substantial departure from generally accepted corrections mental health practices.

6. Staffing

The absence of sufficiently qualified mental health staff at MCMJ contributed significantly to the inadequacy of mental health care. At the time of our tour in September 2003, the MCMJ psychiatrist was required by contract to provide on-site services six hours per week. Six hours a week is grossly inadequate and insufficient to address the mental health care needs of MCMJ's inmate population, which ranges from 1,000 to 1,300 inmates. As stated above in section III.B.1, national studies suggest that approximately 16 percent of male inmates and 23 percent of female inmates can be expected to have a mental illness.[14] Further, despite having a psychiatrist under contract, our review indicated that there were weeks, and sometimes months, with no psychiatric coverage at all. The inadequate psychiatry schedule also directly contributed to the failure to provide inmates with timely psychiatric medications.

The lack of adequate psychiatric staff caused MCMJ to rely on improperly trained staff to identify and address inmates' psychiatric needs. For example, MCMJ used untrained corrections officers to conduct intake screening, which contributed to the failure to identify initially inmates with psychiatric problems. This problem was compounded by MCMJ's reliance on licensed practical nurses who lacked psychiatric training, which contributed to the failure to identify inmates in need of immediate psychiatric care. Such care is crucial in preventing psychiatric decompensation and potential harm to self or others.

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[14] Paul M. Ditton, Bureau of Justice Statistics, Mental Health Treatment of Inmates and Probationers (1999), http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf (last visited September 2, 2008). This study defined a "mentally ill" inmate as any inmate that "reported a current mental or emotional condition, or . . . reported an overnight stay in a mental hospital or treatment program."). Again, we note that recent national studies illustrate a dramatic increase in population of jail inmates with mental health care needs. For example, Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates (2006), http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf (last visited September 2, 2008) reports that 75 percent of female jail inmates, and 63 percent of male jail inmates, have a mental health problem. This study defined an inmate with a "mental health problem" as any inmate that had "a recent history or symptoms of a mental health problem" within the prior 12 months.

C. Use of Restraints

We found that MCMJ's use of four- and five-point restraints,[15] raised significant concerns. In appropriate circumstances, the proper use of such restraints is an effective tool to prevent inmates from harming themselves or others. However, we concluded that MCMJ's monitoring of restrained individuals to be constitutionally deficient, and found serious concerns regarding MCMJ's decisions to apply such restraints. We shared these concerns with the County and the Sheriff in 2003 and in 2007.

1. Monitoring of Restrained Individuals

Restraining inmates, although necessary at times, is a dangerous activity for both inmates and staff because of the force that may be necessary to restrain the inmate. Restrained inmates must be monitored appropriately. The dangers of inadequate monitoring were evidenced by the July 2000 death of a restrained MCMJ inmate from complications caused by necrotizing fasciitis, commonly referred to as "flesh-eating bacteria." According to the Mobile County Special Grand Jury Report regarding this incident, during the 14 days this inmate was at MCMJ, he was stripped naked, handcuffed, and shackled almost continuously. The inmate was reportedly restrained because he clogged the toilet with his clothes, causing it to overflow, and also spread excrement on himself and the cell. Typically, the limbs of a person infected with necrotizing fasciitis will swell and may develop a purplish rash within three to four days of infection. Within four to five days, an infected person will experience critical symptoms, during which the body will go into toxic shock and the person may lose consciousness. Thus it appears that either checks were not performed or, if they were performed, no action was taken. Although this incident occurred several years ago, it informs our review of the MCMJ's current policies and practices regarding the use of restraints. Indeed, the Special Grand Jury Report concluded that "a massive systemic failure in the administration of the Mobile County Metro Jail resulted in" this inmate's death.

Although MCMJ revised its policies following this incident, at the time of our tour, MCMJ policies regarding checks of

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[15] Using four-point restraints means the inmate is placed in a prone position and his or her arms and legs are secured. Five-point restraints also includes restraining the inmate's head.

restrained inmates' welfare ("welfare checks") were inadequate. The revised policies required welfare checks every 15 to 30 minutes, but only required a check of the restrained inmate's extremities for visible injuries. Although some inmates were restrained in the medical clinic, MCMJ did not require checks of vital signs, range of motion, neurological condition, or other physiological checks of the restrained inmate's condition, which are required by generally accepted corrections practices. The limited evaluation required by MCMJ is a substantial deviation from generally accepted corrections practices and unreasonably places inmates at risk of harm. For example, an inmate in restraints who appeared to have delirium tremens - a physical and mental disturbance caused by withdrawal from alcohol use after prolonged drinking - apparently received no treatment for this condition and did not have his vital signs monitored. In addition, restrained inmates may go into respiratory distress, which may be interpreted as agitation or resistance and would not be revealed by a simple check of the inmate's extremities for visible injuries.

The paucity of documentation regarding welfare checks of restrained inmates at MCMJ raised serious concerns that these checks were not performed or were not performed with sufficient frequency to protect inmates from harm. Documenting the basis and duration of the use of restraints and the condition of the restrained inmate is generally accepted corrections practice. However, the only documentation of the basis for, and duration of, the use of restraints by MCMJ were brief notations on the Inmate Restraint Log. The MCMJ policy does not require documentation of welfare checks or the health condition of the restrained person, although we noted a few checks on the Inmate Restraint Log. For example, a welfare check for one restrained inmate was noted at 3:56 p.m., and there was a notation that the inmate was briefly released from restraints to eat at 5:10 p.m., then restrained again at 5:25 p.m. The log does not indicate any other welfare checks were performed, although generally accepted corrections practices require range of motion, neurological and vital signs checks every 15 minutes. In addition, in a number of instances the first notation that an inmate had been placed in restraints occurred when staff noted a welfare check.

The limited content of the welfare checks that were documented reinforces our concerns regarding the scope of the welfare checks performed by MCMJ. For example, most such notations simply indicated "checked," without further elaboration. This does not reflect an adequate evaluation of the physical condition of the restrained inmate and places inmates at risk of harm.

2. Application of Restraints

At the time of our 2003 tour, MCMJ policy provided that officers may use restraints as a "preventative measure" if the officer believed the inmate was a threat to himself or herself or to others. The MCMJ policy did not require supervisory approval for the use of restraints, although the Inmate Restraint Log did have a column to record the name of the supervisor who was notified of the use of restraints. There were numerous examples of the use of restraints for medical purposes, such as for potentially suicidal inmates. Although MCMJ policy required physician approval for the use of restraints for medical reasons, it did not require documentation of the physician's basis for approving the restraints. Thus, we were not able to evaluate whether physician approval was obtained or if the use of restraints was appropriate.

The notations on the Inmate Restraint Log provided only cursory descriptions of the basis for the use of restraints, such as "breaking sprinkler" or "suicidal." In addition, the log was frequently incomplete, and commonly failed to note the date and time that restraints were applied or were removed. In fact, upon our request for completed restraint logs for a one-year period, MCMJ could only provide completed Inmate Restraint Logs for ten non-consecutive days.

Even based on this extremely limited documentation, it was clear that MCMJ utilized restraints successively on the same individuals for extended periods of time, raising concerns regarding the need for the use of restraints. Indeed, our expert corrections consultants noted that the frequency of the use of restraints at MCMJ was atypically high for a jail of its size. Inappropriate use of restraints can be dangerous for both inmates and staff, and MCMJ's failure to document and review the use of restraints was inconsistent with generally accepted correctional practices and put inmates at risk of harm.

The prolonged and successive use of restraints is an improper practice and indicative of a failure to manage disruptive or mentally ill inmates. For example, a particular inmate at MCMJ was placed in five-point restraints in May 2003 for "breaking sprinkler head" at 11:30 p.m. and remained in restraints until 8:30 a.m. the following morning. The inmate was again placed in five-point restraints for "breaking sprinkler head" at 9:15 a.m. and was not released until 6:00 p.m. This inmate was placed in five-point restraints a third time for "breaking sprinkler head" at 6:39 p.m. and the date and time of his release from restraints was not noted. This cyclical use of

five-point restraints indicates that MCMJ failed to either identify and treat an inmate who possibly had serious mental health needs or, if he was not mentally ill, to manage appropriately this inmate's behavioral issues.[16]

D. Security, Supervision, and Protection From Harm

During our tours, we found that MCMJ failed to protect inmates from harm adequately. We noted a high, and increasing, level of inmate-on-inmate violence at MCMJ. For example, in 2003, MCMJ reported 89 fights in four months, an increase of 36 percent over the same period in the prior year. While this statistic alone does not evidence a pattern or practice of deliberate indifference to inmate-on-inmate violence, it is an example of the deficient security practices that subject MCMJ inmates to an unreasonable risk of harm. Our expert corrections consultant concluded that the increasing inmate-on-inmate assaults stem from a variety of deficient MCMJ practices.

Specifically, our review revealed that MCMJ failed to: take adequate measures to limit the introduction of contraband into the facilities; classify inmates appropriately based on their anticipated in-custody behavior; and supervise inmates adequately. Such failures significantly increases the risk of violence, placing both inmates and staff at risk of serious harm. The security, supervision, and protection from harm deficiencies at MCMJ were exacerbated by a lack of adequate policies, procedures, training, and staffing.

1. Control of Contraband

Inmates reported a significant problem with contraband, including illegal drugs, at MCMJ. Our review of MCMJ documents, such as Shakedown Forms, confirmed these reports. The shakedowns revealed inmates possessed various shanks, razors, bleach, and other contraband. For example:

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[16] Furthermore, our review of MCMJ records did not indicate that this inmate's limbs were exercised during this period of time. Failure to attend to a restrained inmate's physical needs during such extensive periods of restraint, such as the range of motion of the inmate's arms and legs, can cause serious medical harm.

- A shakedown conducted in one wedge[17] in February 2002, revealed six razors/shanks, a maintenance screw tip, two metal ceiling pieces, and an ink pen for tattooing, along with other contraband items.

- Similarly, a shakedown of a pod[18] in April 2003, uncovered 13 containers of bleach, which could be used as a weapon.

We also noted some inadequate responses to the discovery of contraband. For example, in April 2002, when staff found an inmate smoking marijuana, the only action indicated in the file was the suspension of the inmate's commissary privileges for one week.

Despite the apparent presence of significant amounts of contraband, MCMJ conducted too few shakedowns. Indeed, although the Cell Condition Check List, last modified in 1999 at the time of our 2003 tour, contained a directive from the MCMJ Warden that shakedowns should be performed once per week, our review indicated they were performed significantly less frequently. One potential source of this problem is a lack of sufficient staffing. According to MCMJ policy, inmates are to be taken to the recreation yard during shakedowns of entire housing wedges, a procedure that requires intensive staffing. However, both MCMJ staff and records indicated that staffing shortages have largely prevented MCMJ from allowing inmates to use the recreation yard, and consequently resulted in fewer shakedowns.

2. Classification of Inmates

Adequate classification systems are a fundamental component of providing a reasonably safe environment in a corrections institution. The primary goal of a classification system is to predict in-custody behavior so that appropriate security measures can be utilized to minimize the risk of violence. Generally accepted corrections practices for classification systems utilize a variety of objective, behavior-based factors to determine the

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[17] A wedge is designed to house 16 inmates. However, MCMJ routinely exceeds this number and therefore it is unclear the total number of inmates housed in this wedge at the time of the shakedown.

[18] Pods housing male inmates consist of six eight-cell wedges. Pods housing female inmates consist of two twelve-cell wedges.

appropriate level of custody. Typically, inmates are divided into high, medium, and low custody, and thereafter receive the appropriate level of freedom and staff supervision for that classification level.

In contrast to generally accepted corrections practices, MCMJ inmates were housed based almost exclusively on whether they have been convicted or whether they are charged with a felony or a misdemeanor. At the time of our tours, male inmates were separated into six groups,[19] and were still housed based primarily on their legal status, not on whether they were objectively dangerous. Female inmates were reportedly separated into two groups, misdemeanents and all others, but our review revealed that female inmates were housed according to available space.[20]

Although the MCMJ classification form collected various behavior-based information, this information was not utilized to classify inmates. Such practice unreasonably increases the risk of harm by failing to perform a meaningful evaluation of anticipated behavior, particularly violent behavior. The MCMJ failed to separate adequately predatory inmates from vulnerable inmates. For example:

- One inmate repeatedly stabbed another inmate in June 2002, with a pen while incarcerated at MCMJ causing multiple puncture wounds to the inmate's head, arms, and back and requiring treatment at a hospital emergency room. However, during a subsequent incarceration at MCMJ in August 2003, the assailant was housed in the protective custody wedge with MCMJ's most vulnerable inmates. This inmate was moved to

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[19] Specifically: 1) inmates charged or convicted in the federal system; 2) inmates convicted of felonies in the state system; 3) inmates charged with "low" and "medium" felonies; 4) inmates charged with "high" felonies; 5) inmates charged with or convicted of misdemeanors; and 6) special management inmates (including sex offenders and disciplinary and protective segregation). We understand that since our tours, the U.S. Marshal's Service has clarified that MCMJ is not required to separate federal inmates from other inmates. However, this does not impact the lack of an adequate behavior-based classification system.

[20] Since our tours, MCMJ reports that it has begun housing some female inmates in the Barracks.

disciplinary segregation after altercations with another inmate and staff.

- In another incident in July 2003, an inmate was taken to the disciplinary wedge because he had just been involved in a fight with another inmate. However, he was not isolated, but was placed in a cell with an inmate. He assaulted this inmate almost immediately, and the assaulted inmate required hospital treatment for a cut above his eye.

While the factors considered in an objective classification system include whether the inmate has been convicted of the current offense and the nature of that offense, numerous other behavior-based factors also must be considered. As there are violent misdemeanor offenses[21] and misdemeanor arrestees and offenders who have known predatory histories, as well as the fact that there are many non-violent felonies, basing custody levels solely on an inmate's legal status does not adequately predict in-custody behavior. A meaningful classification system is even more important in crowded facilities like MCMJ. For example, our expert corrections consultant noted that it is safer for staff and inmates for MCMJ to increase the population density of low or medium custody inmates, rather than high custody inmates. An appropriate classification system would permit MCMJ to allocate scarce space and resources appropriately to provide a reasonably safe environment. Without such a classification system, inmates and staff at MCMJ face an unacceptably high risk of harm.

3. Supervision

We found that MCMJ failed to supervise inmates adequately. The MCMJ is a remote-supervision jail, in which staff observe inmates from a control area and are separated by glass walls from the inmates in the six wedges.[22] An officer assigned to the control area cannot leave the post, except in emergencies, and therefore floor officers are needed as additional security staff

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[21] Some examples of violent misdemeanors include the following: assault in the third degree, Ala. Code § 13A-6-22 (2007); sexual abuse in the second degree, Ala. Code § 13A-6-67 (2007) (includes sexual contact with a person who is legally incapable of consent for reasons other than age); and reckless endangerment, Ala. Code § 13A-6-24 (2007).

[22] This is in contrast to direct-supervision jails, where staff are stationed in the housing unit.

to inspect the pods, perform shake-downs for contraband, and ensure inmates' safety.

The MCMJ policies required a welfare check of the inmate population every 30 minutes. However, such checks were only occasionally noted in the pod logs, which raised concerns that they were not being conducted. In addition, there were no guidelines for the conduct of such checks and no consistent documentation of what staff observed during such checks. Such inadequate supervision practices place both inmates and staff at risk. For example, in April 2002, three inmates were assaulted in their cell by two other inmates, with one of them suffering bruising to his neck, face, and arm and a split lip. Although the cells at MCMJ are in the line of sight of the pod officer's station, security staff did not notice the assault in the cell, and the assault was only brought to light when one of the assaulted inmates approached an officer.

The floor officers at MCMJ were required to inspect the condition of each pod once per shift. However, staff failed to identify many deficiencies during these inspections. For example, during one of our tours in 2003 we noted that several windows to the outside of the facility were cracked or had holes in them, and had apparently been broken for some time. This poses a significant security risk.

The MCMJ's security regarding escape prevention is also of concern. We have learned that in 2007, a 19-year-old female inmate at MCMJ allegedly attempted an escape, and reportedly was only discovered when she was badly cut trying to climb the razor fence surrounding the facility. It appears that MCMJ does not know how this inmate made her way outdoors to be in a position to charge the fence, or why she was not discovered until she had suffered an injury on the fence.

4. Policies, Procedures, Training, and Staffing

The deficiencies we identified in security administration at MCMJ stemmed in large part from a lack of adequate policies, procedures, training, and staffing. The MCMJ policies did not adequately address the operation of the facility. For example, as noted above, the policies regarding facility inspections and inmate welfare checks did not establish standards for these evaluations and did not provide for a systematic mechanism to address deficiencies identified by staff, thereby greatly reducing their efficacy. Similarly, MCMJ policies did not provide for adequate documentation of significant events, such as

the use of force, the use of restraints, and facility inspections.[23]

In addition, although the corrections officer who was in charge of inmate discipline at the time of our tour in 2003 was striving to administer discipline fairly, the disciplinary procedures at MCMJ had significant problems. While these problems did not violate the Constitution, our expert corrections consultant noted that they significantly increased the tension in the facility and fostered inmate-on-inmate violence.

The MCMJ policy allowed for informal "sanctioning" of inmates, including locking-down inmates for up to 72 hours with no opportunity for the inmate to be heard or appeal the decision.[24] Our review indicated that the same type of violation would at times be referred for formal disciplinary proceedings, and other times the inmate would be sanctioned informally. While not a constitutional violation, we flag these practices because they give the perception that discipline is imposed arbitrarily, which increases the risk of inmate-on-inmate violence.

We observed that MCMJ staff did not receive adequate training. At the time of one of our tours, a number of the corrections officers hired in the last few years did not receive pre-service training. In addition, until recently, MCMJ staff were not receiving any in-service training.[25] Thus, a number of officers only received training through the Field Training Officer ("FTO") program, where officers are paired with an experienced officer for two weeks. In addition, we identified significant deficiencies with the FTO program. The MCMJ did not have written procedures governing the selection of FTOs, to ensure that FTOs are exemplary officers and demonstrate an interest, knowledge, and ability to train new officers in MCMJ

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[23] The MCMJ reports that, following our tours, it developed an unusual occurrence form and an use-of-force form, which are centrally filed and reviewed. We have been unable to verify this information.

[24] The MCMJ reported that, following our tours, it had modified the sanction process. Reportedly, MCMJ no longer conducts informal discipline unless the inmate signs a written waiver of the hearing. We have been unable to verify this claim.

[25] We understand the MCMJ has since offered some in-service training and plans to offer pre-service and additional in-service training.

policies and procedures. The FTO program also did not describe the knowledge, skills, and abilities that trainees must demonstrate and simply listed the topics to be covered, such as "Cell Inspections" and "Sick Call/Sick Slip." Similarly, MCMJ did not document the performance of the trainees in these topics and FTOs simply noted the date the topic was covered with the trainee.

Other corrections officers did receive pre-service training, but the curricula we reviewed indicated the training provided was inadequate. The MCMJ training materials revealed that not nearly enough training was devoted to critical jail functions. For example, the training on the use of restraints and transporting prisoners was last revised in 1991, and did not adequately address the procedures for applying restraints. Moreover, the training was apparently a lecture format, with no practical component.

Staff reported, and our review corroborated, that MCMJ did not have adequate numbers of corrections staff. The MCMJ corrections staff worked a large amount of overtime. For example, it spent $1.5 million on overtime for corrections staff in 2002. Yet the Jail still lacked sufficient staff to operate the facility. The staff vacancy rate in 2003 was reportedly 28 percent. The heavy use of overtime also raised concerns about officer fatigue, which can increase the risk of harm to inmates and staff.

The MCMJ also provided inadequate access to exercise, which is a significant mechanism corrections facilities use to decrease inmate aggression. The MCMJ had no indoor exercise facilities and, by its own admission, made limited use of its outdoor exercise yard. The MCMJ did provide some very limited outdoor recreation, and so did not violate the Constitution, but the very limited recreational opportunities raised tensions and thereby fostered inmate-on-inmate violence. Appropriately structured and supervised exercise provides an important outlet for inmate aggression, and thus, is an important inmate management tool. Futhermore, regularly scheduled exercise provides a privilege that staff can take away from an inmate for sustained rule violations. However, MCMJ's outdoor yard was utilized on only 45 days in 2002. Although MCMJ apparently has improved access somewhat since that time, it was still significantly limited at the time of our tour.

E. Safety and Sanitation

Although conditions at the Barracks were significantly better than at the Jail at the time of our tour in 2003, safety and sanitation conditions at both the Jail and the Barracks posed a significant risk of disease and injury to inmates and staff. We identified deficiencies in the areas of insect and rodent control, physical plant, fire safety, and general sanitation and safety. Similar to the security administration deficiencies discussed above, the safety and sanitation failures were exacerbated by the crowded conditions at the Jail. In 2007, we provided the County and the Sheriff a written report prepared by our expert corrections safety and sanitation consultant outlining our concerns.

1. Insect and Rodent Infestation

We found that there was a significant insect and rodent infestation at the Jail. We observed rodent droppings and a live rat in the kitchen during the height of lunch preparation. Insects and rodents in the kitchen area can spread food-borne illnesses, such as by carrying salmonella bacteria.[26] We also saw ants and unidentified black bugs throughout the Jail. Insects can spread disease and, given the general sanitation problems, insect bites can become infected. As discussed in section III.A.3, we noted an outbreak of a skin infection at MCMJ.

2. Physical Plant

Following our tours in 2003, MCMJ took a number of steps to reduce the inmate population and reported that, as of December 3, 2003, the inmate census had been reduced to 1,006 inmates; 817 in the Jail, and 189 in the Barracks. Unfortunately, this trend did not continue, and the Jail presently remains dangerously overcrowded. Since the start of our investigation, we have received many allegations of inmates being forced to sleep on the floor of their cells due to overcrowded conditions; some inmates sleeping just inches from toilets and sinks, including an inmate that was allegedly non-ambulatory.

At the time of our tour, there were a number of plumbing problems at the Jail, although we did not identify such problems

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[26] We understand that following our tours, MCMJ has instituted periodic pest control visits covering the entire facility. We have been unable to verify this assertion.

at the Barracks. We observed inoperable showers and toilets throughout the Jail facility. For example, we observed numerous leaking toilets, including in cells with inmates sleeping on the floor near the leaks. In addition, we measured hot water temperatures above 120 degrees, which create a scalding threat to both inmates and staff. For example, the shower water temperature in one of the female units measured 130 degrees, which can cause burns in less than 30 seconds. These water temperatures allow inmates to harm themselves, accidently or intentionally, and provide a weapon for inmates who want to harm others.

3. Fire Safety

We identified several deficiencies in MCMJ fire suppression and evacuation systems and procedures. For example, there were no sprinkler heads over the ovens in the kitchen or behind the dryers in the Jail, two places where fires are likely to originate.[27] We also identified deficiencies in evacuation systems and practices. For example, one fire door took over two minutes to open and another could not be opened by staff. Additionally, MCMJ has inadequate procedures to evacuate the facilities in the event of an emergency. We also noted several exit lights that were not working, impeding evacuation in the event of a fire.

4. General Sanitation and Safety

Many of the showers contained mildew and mold. Moreover, the laundry facilities do not adequately sanitize the clothing, which increases the risk of transmitting infectious diseases, such as skin infections.[28] In addition, the sink in the laundry room did not have a vacuum breaker to prevent back-flow from contaminating the potable water system.

Chemical safety was also inadequate at MCMJ. For example, we observed a container in the medical clinic marked "bleach"

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[27] We note that MCMJ retained a new sprinkler-maintenance contractor shortly before our first tour, who was reportedly working to correct these problems. The MCMJ reported that, following our tours, it has worked with the Fire Marshal to identify and correct fire safety problems and conducted fire safety training.

[28] We understand that since our tours, MCMJ has acquired new washing machines.

that actually contained an ammonia-based chemical. Such mislabeling poses a significant risk of harm to inmates and staff because it may lead to accidental mixing of chlorine and ammonia-based chemicals, which releases highly toxic chlorine gas. In addition, inmate workers in the laundry were using corrosive chemicals without protective equipment such as goggles to prevent injury.[29]

IV. RECOMMENDED REMEDIAL MEASURES

In order to address the constitutional deficiencies identified above and protect the constitutional rights of inmates, MCMJ should implement, at a minimum, the following measures:

A. Medical Care

1. Revise intake procedures and the Jail Receiving Screening form to screen incoming inmates adequately. Ensure that a qualified medical professional reviews all screening on a timely basis.

2. Develop and implement a policy to ensure that a qualified medical professional completes a timely health appraisal of each inmate.

3. Develop and implement chronic disease policies and procedures that adequately identify inmates with chronic diseases and ensure adequate and timely monitoring of, and follow-up care for, inmates with chronic diseases.

4. Develop and implement adequate policies and procedures regarding the identification and treatment of contagious diseases such as tuberculosis and syphilis.

5. Develop and implement procedures to assure timely and appropriate access to medical care through sick call.

6. Develop and implement protocols specifying the appropriate response[s] to common acute symptoms.

7. Develop and implement policies and procedures that ensure timely and appropriate delivery of prescription medications.

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[29] The MCMJ reports that, following our tours, it has taken various measures to address chemical safety issues.

8. Continue working with the Department of Health to prevent, diagnose, and treat the outbreak of skin infections. Develop and implement policies and procedures to address the likely causes of the outbreak and to treat infections.

9. Provide sufficient staffing to ensure that inmates' serious medical needs are met.

B. Mental Health Care

1. Revise intake procedures and forms to screen adequately incoming inmates for mental health issues. Ensure that a qualified mental health professional reviews all screening on a timely basis.

2. Ensure that staff conducting intake screening are trained adequately.

3. Develop and implement procedures to ensure inmates with mental health needs receive timely assessment by a qualified mental health professional.

4. Develop and implement policies and procedures to ensure timely and adequate responses to inmate requests for mental health care.

5. Ensure adequate on-site psychiatry coverage, and ensure adequate on-site supervision of mental health staff.

6. Develop and implement policies and procedures that ensure adequate monitoring and follow-up treatment of inmates with mental illness.

7. Develop and implement adequate suicide screening policies and procedures.

8. Ensure that inmates receive psychotropic medications in a timely manner and that inmates have proper diagnoses for each psychotropic medication they receive.

C. Use of Restraints

1. Develop and implement a policy regarding the application of restraints that requires immediate prior written approval, if practicable, of the use of restraints for medical purposes by a qualified medical professional or immediate prior written supervisory approval, if practicable, for uses of restraints for security purposes, other than the use of

routine restraints for transporting inmates, such as handcuffing.

2. Develop and implement a policy regarding monitoring restrained inmates that requires adequate checks of the physical condition of restrained inmates, and adequate documentation of the use of restraints, including the basis for and duration of the use of restraints and the performance and results of welfare checks on restrained inmates.

D. Security, Supervision, and Protection From Harm

1. Develop and implement an objective, behavior-based classification system that separates inmates in housing units by classification levels.

2. Develop and implement written procedures for conducting and documenting security inspections and inmate welfare checks, including specific criteria for such evaluations and a systematic procedure for correcting any deficiencies identified.

3. Provide adequate corrections officer staffing and supervision to ensure inmate safety.

4. Develop and implement appropriate training for corrections staff addressing security administration and providing for proficiency testing.

5. Develop and implement policies governing the conduct of shakedowns that increase the frequency and identify the scope of shakedowns in order to minimize inmates' access to dangerous contraband.

6. Develop and implement policies requiring adequate documentation and investigation of significant events, including use of force by staff and instances of inmate-on-inmate assault.

E. Safety and Sanitation

1. Ensure regular and periodic cleaning and maintenance of all housing areas, including toilets and showers. Ensure regular and periodic insect and rodent control measures are performed.

2. Ensure proper operation of all fire detection and suppression systems. Develop and implement adequate evacuation procedures, including emergency door inspections.

3. Adjust the hot water in all housing areas to safe temperatures.

4. Develop and implement proper chemical safety measures.

V. CONCLUSION

We note again in conclusion the extraordinary and unexpected step taken by the County and Sheriff to cease all communications with the Department of Justice regarding this investigation, and the negative inferences we drew regarding the present status of the conditions at MCMJ in light of this action. Nevertheless, we once again invite the County and Sheriff to discuss with us the remedial recommendations we presented in this letter, with the goal of remedying the identified constitutional violations without resort to litigation.

In the event we are unable to reach a resolution regarding the above identified constitutional violations, we are obligated to advise you that the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, 49 days after receipt of this letter, to correct identified deficiencies or otherwise protect the rights of the inmates incarcerated at MCMJ. 42 U.S.C. § 1997b(a)(1). If you have any questions regarding this letter, please contact Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Grace Chung Becker

Grace Chung Becker
Acting Assistant Attorney General

cc: Lawrence M. Wettermark, Esq.
Attorney for the Mobile County Commission

James B. Rossler, Esq.
Attorney for the Mobile County Sheriff's Department

Michael W. Haley
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Mobile County Metro Jail

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U.S. Department of Justice
Civil Rights Division

SYC:TMG:JA:WEN:db
DJ 168-3-38

Special Litigation Section - PHB
950 Pennsylvania Avenue, NW
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May 29, 2009

Via Facsimile and Federal Express Mail

James B. Rossler, Esq.
Attorney at Law
Number One South Royal Street
Third Floor
Mobile, AL 36602

Re: Mobile County Metro Jail

Dear Mr. Rossler:

As you know, the United States has an ongoing investigation of the Mobile County Metro Jail ("MCMJ"). This letter is to follow up on our Findings Letter issued on January 15, 2009 pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997.

In the Findings Letter, we recommended several remedial measures to address the constitutional deficiencies present in the MCMJ. We also invited you to discuss with us those proposed remedies. We have attempted to contact you by phone at your office on two separate occasions since issuing the Findings Letter. We have yet to hear back from you. We write today to request your cooperation and encourage you to engage with us in resolving this important matter.

As an initial matter and by way of background, we remind you that throughout the pendency of this investigation we have consistently sought your cooperation. However, while negotiating mutually agreeable terms and conditions for a 2006 re-tour of MCMJ, the County and the Sheriff abruptly discontinued all communications with the Department of Justice. This occurred despite our acquiescence to your request for the written reports prepared by our consultants that identified deficiencies at MCMJ and made recommendations on how to correct those deficiencies. As you are aware, we made repeated attempts to reinitiate communications throughout 2007. Finally, we were forced to continue our investigation absent your cooperation. The result was the issuance of our Findings Letter.

We have and will continue to conduct this investigation in a fair, objective and transparent matter. The Findings Letter and the legal conclusions therein are based on our careful analysis of the facts gathered during our entire investigation and on the applicable law. We made these findings only after conducting a thorough review[1] of conditions at the facility, accompanied by nationally recognized consultants with expertise in the fields of correctional management and medical care. As noted above, in the spirit of transparency and in an effort to provide expedited technical assistance to the County, we shared the experts' reports with you.

Notwithstanding your silence to date, we note that the Attorney General is obligated under CRIPA to investigate allegations of constitutional violations, make findings and, if unconstitutional conditions exist, remedy them - first by encouraging correction of the conditions through informal methods. Alternatively, we are obligated to advise you that the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA to protect the rights of the inmates incarcerated at MCMJ should we be unable to cooperatively resolve the deficiencies identified in our Findings. Indeed, until we arrive at a resolution of our very serious concerns, the investigation remains open.

We remain hopeful, however, that the Sheriff and the County's ultimate goal is to ensure constitutional conditions of confinement for its inmates. Therefore, we remain confident that we can work cooperatively with you toward resolving our investigation and achieving the shared goal of remedying the identified constitutional violations present at MCMJ.[2]

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[1] Specifically, we conducted several tours where we interviewed the Sheriff, his staff and numerous inmates. We reviewed documents produced by the facility, including state and county inspection records, jail policies and procedures, several months worth of incident reports, and individual inmate records. At the end of our tours, our expert consultants conveyed to you their preliminary findings in the form of technical assistance. Finally, after a more thorough review of the documents provided, the consultants prepared reports which we utilized to prepare our assessment regarding the constitutionality of conditions at MCMJ.

[2] Our Findings Letter recommended a list of remedial measures that constitute the minimum necessary to protect the constitutional rights of MCMJ inmates. Our proposed resolution will mandate only those measures necessary to achieve this goal.

Accordingly, we invite you to meet with us as soon as possible to discuss resolving the concerns outlined in our Findings Letter as well as to discuss any concerns or questions you may have.

Sincerely,

William E. Nolan
Senior Trial Attorney
Special Litigation Section

cc: Larry Wettermark, Esq.

U.S. Department of Justice
Civil Rights Division

JMS:AS:EG:CNC:ES:mrb
DJ 168-3-38

Special Litigation Section - PHB
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October 18, 2012

James B. Rossler, Esq.
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Number One South Royal Street
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Mobile, AL 36602

Jay Ross, Esq.
County Counsel
Mobile County Commission
205 Government Street
Mobile, AL 36644

Re: Mobile County Jail (DJ 168-3-38)

Dear Counsel:

We write now to offer our assessment of current conditions at the Mobile County Jail, and to invite the County to engage in a dialogue to amicably resolve this ongoing investigation. Our assessment of current conditions is based largely on information obtained in the course of our January 17-20, 2012 inspection of the facility and the documents you recently provided us.

At the outset, we thank you and your clients for the cooperation we received during our inspection. Jail staff provided our expert consultants with the access requested, responded to our numerous requests for documents,[1] and did not interfere with our private interviews with witnesses. We greatly appreciate this new level of cooperation. We hope to build upon it by working together with you to address the challenges still facing Mobile County Jail.

As we discuss in detail below, the Jail has made progress since our last tour. The most significant improvements relate to the Jail's provision of medical services. Most of the remaining challenges concern safety and security and mental health issues. In these two critical areas, a number of jail practices, which we found failed to meet minimum constitutional standards after our initial tour, are still in place. We look forward to working with you in the coming weeks to develop an agreement that addresses these remaining areas of concern.

[1] The one exception to this cooperative approach to our document requests has been the County's resistance toward producing documents associated with the alleged killing of an officer by an escapee. We renew our request for documents relating to this incident.

CURRENT CONDITIONS

A. Protection from Assaults

Assaults are occurring at the Jail at an unacceptably high rate. In 2011 alone, there were more than 300 inmate-on-inmate assaults at the facility. An example of the violence is what occurred at one of the female units on October 1, 2011, when a number of fights broke out almost simultaneously among a crowd of inmates.

Assaults are occurring at the jail principally because of three systemic problems: (1) deficient classification and housing assignments, (2) overcrowding, and (3) deficient use of force monitoring by video. These systemic deficiencies combine to subject inmates to unreasonable and excessive levels of risk. Indeed, our security expert believes there is a substantial risk of even greater amounts of violence in the near future unless these issues are addressed.

The systemic problems we observed during our most recent tour of the facility mirror the problems seen in the past. After we originally toured, we identified the very same three systemic issues that are continuing to jeopardize inmate safety to this day.[2] We are therefore providing you with additional notice that the Jail needs to remedy these conditions to meet minimum constitutional standards in the area of safety and security. Below, we discuss the three systemic deficiencies contributing to inmate-on-inmate violence in greater detail.

Deficient Classification and Housing Assignments: The Jail's classification and housing assignment process remains one of its most serious deficiencies. Classification is one of the foundations for safe jail operations. Failure to properly separate prisoners based on their level of dangerousness places them at serious risk of harm. Aggressive prisoners prey on weaker prisoners. Members of different neighborhood gangs, who find themselves in the same housing unit end up in preventable altercations. The more dangerous prisoners are quick to turn violent on cellmates with mental illness. Poor classification and housing practices can even lead to mass disturbances, as tensions overflow, leading to fights that cannot be readily controlled by staff. When such events can be prevented in the first place through a sound classification process, the Constitution requires that a jurisdiction address them as a foreseeable and preventable condition.

Unfortunately, the Jail continues to rely on a charge-based housing assignment process, which cannot provide sufficient assurance that more dangerous prisoners are being separated from less dangerous prisoners. The current system lacks a number of the most basic components of a sound classification and housing assignment process, such as systematic and routine

[2] We recognize that improvements to training and supervision have been made that will have a positive effect on the safety of the Jail's inmates. Officers receive at least 80 hours of initial training during their first year of service. While the training program needs to be improved on two significant topics – the Prison Rape Elimination Act and mental health supervision – we otherwise have no major concerns regarding staff security training. The Sheriff's Department has also improved supervision, relying less on staff overtime, modifying policies, and implementing a system to track the frequency of rounds in general housing. Despite these positive developments, as discussed below, the constitutional mandate to protect inmates from harm requires the Jail to do more.

evaluation of past institutional history, special supervision needs, physical characteristics, age, and other factors indicating potential vulnerability or aggression. A sound classification process does more than just protect prisoners from predation. It also serves other security needs, including helping staff identify gang problems and allocate limited housing resources. Yet, the Jail classification staff have little familiarity or training on the types of objective classification systems commonly used in other facilities across the nation. The problem is particularly pronounced in the female units. For instance, we found female prisoners who were living in the same housing units despite charges that varied widely, from robbery to criminal mischief. In other words, the Jail houses female inmates together without much consideration of their charges, let alone more objective classification factors. The Jail also has some physical plant issues that affect staff's ability to separate detainees properly. For instance, housing options are limited throughout the facility, with very little space in the booking area and only a few pods available for females. Moreover, some cells still have broken locks, allowing detainees to "pop" open their cells and freely roam units. These types of physical plant problems limit staff's ability to place detainees in a safer environment. Instead, housing decisions tend to be driven by availability of space, rather than appropriate security considerations.

Overcrowding: Systemic overcrowding exacerbates the security deficiencies at the Jail. Such conditions make the environment even more tense and intolerable. When crowding limits housing space, it leads to unhealthy conditions, strains staff resources, and creates an array of security-related challenges.

From July to December 2011, the Jail population was over capacity by as much as 77.5 percent. In sampled units, approximately a third of the male inmates lacked bunks. The percentage of female detainees without bunks was over 50 percent. In some instances, we found inmates sleeping near toilets in crowded cells. In one striking example, we observed a female inmate, almost nine months pregnant, sleeping on the floor. She had been without a real bed for nearly four months. Our experts noted that overcrowding has significantly compromised the distribution of hygiene materials, the provision of exercise opportunities, and supervision of detainees.

The violence at the facility tracks and has a relation to the facility's difficulties with overcrowding. For example, a disproportionate amount of the violence is occurring in the female units, which generally are the most overcrowded. Our expert also observed that crowding has compromised the staff's ability to conduct high frequency rounds for individuals at risk of suicide.

Although the Jail administration has had some recent success in restraining population growth and dealing with staffing pressures, we remain concerned about the near- and long-term future of the facility. The inmate population for most of 2011 was actually higher than when we first learned of the problem in 2003, and there is no reason to believe the situation will improve. At the same time, resource and space issues continue to affect Jail operations, and it is unclear what long-term planning exists to assess and deal with community population growth. Put another way, if crowding is an issue now, it is likely to be an even more serious issue in the near-future. Yet, we have little assurance that the County is prepared to take necessary steps to address any problems in a long-term way.

Deficient Use of Force Monitoring by Video: Consistent video monitoring of instances when staff has had time to prepare for their use of force provides an important safeguard against misconduct. The practice not only provides managers with an effective way of identifying those who use force inappropriately, it serves as a prophylactic against misconduct. Despite the utility of video monitoring, we found that Jail staff often fails to videotape the use of force, even for planned cell extractions. Unless the Jail acts to address this deficiency, in combination with the Jail's other security-related deficiencies, the failure to appropriately video staff's use of force will inevitably lead to the unauthorized or excessive use of force as a tactic for handling disruptive inmates.

B. Mental Health Care

Care for inmates with mental illness, including the supervision and treatment of suicidal detainees, has clearly improved since our last tour. Our consultants were impressed with changes adopted by the mental health administrator, the Jail psychiatrist, nurses, and mental health staff. Detainees have timely access to key mental health personnel, including the professional staff, and generally receive necessary medications. A variety of mechanisms, including those built into the electronic record-keeping system, have improved follow-up and continuity of care.

Despite these improvements, a number of practices at the facility work in concert to create conditions of confinement for inmates with mental illness (some of whom also have developmental disabilities) that fail to meet minimum constitutional standards. The Jail houses much of its special needs population, including its inmates with mental illness, in four pods and a quiet room that are also routinely used to house other inmates. This approach leads to conditions that resemble disciplinary segregation for inmates with serious mental illness. It is an approach that is unduly restrictive and untherapeutic, and causes harm to inmates with mental health issues. Many of the Jails remaining challenges concerning the treatment of inmates with mental illness relate to the failure of security staff to involve mental health staff appropriately when making decisions affecting inmates with mental illness. Below we detail the systemic deficiencies that have compromised the facility's ability to protect its inmates with mental illness from harm and/or deprived these vulnerable inmates of the medical/mental health treatment they need:

Improper Use of Restraints on Inmates with Mental Illness: In our findings letter, we reported that staff use restraints as a "preventative measure," in circumstances where a prisoner with mental illness may be a management problem. Our concern was that security staff were using restraints inappropriately instead of ensuring proper mental health treatment. We recommended improvements to communications, training, and coordination between departments. We expressed our concern that without such improvements, the Jail would violate prisoners' rights by placing them in unduly restrictive conditions that could actually be dangerous to both staff and inmates. When misapplied, restraints can increase disruptive behavior, triggering an escalating staff response that in turn results in harm to the prisoner. Moreover, when a restraint is unnecessary, using it is itself a serious deprivation of a liberty interest. Despite some improvements, security administrators and mental health staff still fail to appropriately coordinate, monitor, and review the security staff's use of restraints. Security staff place detainees in restraints ostensibly for mental health reasons, without actually notifying

mental health staff. Worse still, after an inmate is placed in restraints, not enough is done to ensure that security and nursing staff promptly refer the inmate to mental health staff for professional evaluation and treatment. These practices pose a serious risk to inmate safety. Security staff should not be allowed to use medical restraints for "treatment" reasons without medical approval. Moreover, these practices lead to mental health staff inaccurately reporting a very low frequency of restraint use through their quality assurance systems, possibly leading administrators to believe they have attained a reduced level of restraint use.

Improper Placement Decisions for Inmates with Mental Illness: A similar breakdown in communications between security and mental health/medical staff exists in regard to the process for deciding placements for inmates with mental health issues. Without appropriately consulting with medical and mental health staff, security staff decide on whether to place such inmates in special needs housing or isolation, and how long to keep them in such units. These important placement decisions can profoundly affect the mental health of a particularly vulnerable population. A failure to appropriately consult with mental health staff is resulting in the placement of inmates at risk of suicide or decompensation in isolation when such a placement is medically contraindicated.

Absence of Clear Procedures for Transitioning Inmates With Mental Illness to Less Restrictive Settings: The Jail does not have a clear "step down" process (i.e., a policy and procedure for moving detainees with mental illness from different levels of restrictive housing based upon periodic re-evaluations of each detainee's changing needs).

Inadequate Training for Security Staff: The Jail inadequately trains staff assigned to mental health units. Although the mental health staff have made a commendable effort to increase training for all personnel, special needs units need to be staffed by individuals with more specialized skills, temperament, and experience. Staff supervising mental health units require additional training because they have to deal with some of the most seriously ill and behaviorally challenged inmates. The Jail, however, does not ensure that these staff receive such specialized training.

Excessive Reliance on a "Buddy System": As we reported in our findings letter, the Jail routinely utilizes prisoner "buddies" to observe special needs detainees. This problematic practice continues. While careful use of trained "trustees" may be acceptable in limited circumstances, the Jail's actual practices lack important safeguards. The Jail essentially drafts prisoners who happen to be work-eligible to serve in a particularly difficult, high-stress position. The "buddies" watch over suicidal inmates, with little special training, evaluation, or coordination with mental health staff. Under such circumstances, the "buddies" inadequately substitute for proper jail staffing and treatment. Prisoner "buddies" who are not temperamentally fit for such a challenging position and are given too much responsibility may take advantage of inmates with mental illness. In the worst case scenario, such "buddies" may actually abuse their charges.

Problems Relating to Supervision of Suicidal Inmates: While the Jail's screening instruments alert staff to the needs of its suicidal inmates, the Jail is failing to respond with

adequate levels of supervision and appropriate documentation of cell checks.[3] We found that supervision is particularly poor in certain instances because staff place suicidal prisoners in remote cells that are located away from staff posts and cannot be readily supervised. The facility should not place its suicidal inmates at risk in this way. The level of supervision for suicidal prisoners needs to more closely track the acuteness of a prisoner's conditions. A failure to do so, will inevitably lead to tragic results.

Failure to Clearly Define Terms in Policies Relating to Mental Health Care: The Jail's policies and forms employ a confusing variety of related definitions and concepts, and the staff themselves have varied interpretations of terms such as "suicide watch" or "psychiatric observation." The confusion undermines the staff's ability to coordinate in protecting the constitutional rights of inmates with mental illness or with developmental disabilities.[4]

Overcrowding: Finally, as with security issues, overcrowding contributes to the problems with mental health care. The Jail has limited numbers of suicide-resistant/mental health facilities, especially for women. Cells used for housing suicidal prisoners have features that render them unsafe for such purposes (e.g. protruding fixtures). Staff rounds in mental health housing areas are not occurring with sufficient documented frequency, in part because of limited staffing resources and gaps in policies.[5]

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[3] Problems with control of medication contraband and the fact that "suicide" observation cells have not been retrofitted to eliminate obvious suicide hazards further increase the risk of serious incidents occurring.

[4] The County also needs to make sure prisoners have clear notice regarding policies and procedures, including policies on how to access medical and mental health care. We remind the County that pursuant to Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000d et seq. (Title VI), the Jail must take reasonable steps to ensure meaningful access for persons with limited English proficiency. See Lau v. Nichols, 414 U.S. 563 (1974); Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("LEP"). 67 Fed. Reg. 41,455 (June 18, 2002) (DOJ Guidance). Our expert noted that there were roughly 20 to 30 Latinos being admitted to the Jail each month, suggesting that the Jail needs to be mindful of its Title VI obligations going forward. At present, the Jail does not appear to be taking even basic steps to provide language access. For example, currently there is no Spanish language translation or summary of the Jail's handbook, a document distributed to inmates that details the facility's most essential rules and procedures.

To assist your development of an LEP Policy and Implementation Plan, we direct your attention to the section of the Guidance that addresses LEP issues in corrections, 67 Fed. Reg. at 41,469, and a planning tool issued by DOJ entitled Considerations for Creation of a Language Assistance Policy and Implementation Plan for Addressing Limited English Proficiency in Corrections. Both provide specific guidance on how to create and implement a plan to address common situations involving LEP individuals in the corrections setting, and it can easily be adapted to fit the needs of the Jail. Both documents are available at the DOJ LEP website, www.lep.gov. The specific address for the Guidance is http://www.gpo.gov/fdsys/pkg/FR-2002-06-18/pdf/02-15207.pdf. The planning tool is available at: http://www.lep.gov/resources/LEP_Corrections_Planning_Tool.doc.

[5] The Jail does not have any mechanism for providing constant staff supervision. For some of the most acutely ill detainees, even 15-minute welfare checks are not sufficient. We should also note that the documentation of welfare checks raises concerns about record-keeping practices. In some of our samples, staff logs indicated checks at nearly exact 15-minute intervals. This type of exact timing suggests either the rote completion of logs or a practice of conducting rounds on a non-random schedule. Rounds need to be both frequent and random to minimize the risk that prisoners will take advantage of the officer's predictability in timing unsafe or illicit activities.

C. Medical Care

Since our last inspection, the Jail has significantly increased medical staffing, adopted a new electronic record-keeping system, and implemented a variety of policies designed to conform to contemporary professional standards. All of these improvements are commendable, and our medical and mental health consultants do not have major concerns about the medical system generally. We offer, however, a number of technical assistance recommendations to address identified weaknesses in the medical system.

Improvements Should be Made to the Electronic Medical Record System: We recommend that the County continue to update and improve the electronic medical record system. At present, certain areas of improvement, such as chronic care and continuity of care, are at some risk of deteriorating. Because the Jail does not have all of the procedures and safeguards needed to ensure that detainees with chronic conditions receive periodic assessment, treatment, and follow-up, we are concerned about whether the Jail can continue to provide such detainees with necessary care. In practice, the problem is not currently serious enough to warrant a finding of gross constitutional inadequacy. Because the medical record-keeping system helps to flag follow-up appointments, and because physicians and medical staff have been diligent in seeing patients, individuals with chronic illness who might otherwise have fallen through cracks in the system are actually being seen. The problem is that this type of compliance depends heavily on the practices of key staff, such as the mental health director and psychiatrist. If even a few of the medical or mental health professionals leave or are replaced, a completely different clinical approach could lead to a different finding. We also note that the electronic medical record system is still being adjusted to make it less cumbersome and more reliable. At present, it can take dozens of steps for staff just to make a few entries, and staff still rely on paper records for critical functions.

Improvements Should be Made to the Quality Assurance and Internal Management System: The County should continue to update and improve the quality assurance and internal management system. While the medical contractor has processes in place, specific attention should be given to monitoring the nurse-driven health assessments, ensuring that medications that need to be taken without interruption are administered consistently (e.g. HIV medications), tracking individual staff training needs, and improving documentation on follow-up after outside medical visits.

CONCLUSION

Based upon what we learned during our recent inspection, we conclude that the Jail has improved significantly since our last 2003 tour, but that serious issues relating to detainee safety and the conditions of confinement of the mentally ill remain. Those issues include: 1) Classification, 2) Use of Restraints, 3) Suicide and Mental Health Observation, and 4) Overcrowding.

We are eager work with you to resolve these outstanding issues and are determined to avoid a repetition of the breakdown in discussions that occurred in this case from 2003 to 2009. In order to move this matter forward, we propose a teleconference to discuss a practical

agreement resolving all areas of concern. To facilitate discussions, we have attached a draft framework for such a discussion.

If you have any questions, please feel free to call me at (202) 514-8892.

Sincerely,

Christopher N. Cheng
Attorney

SETTLEMENT AGREEMENT

I. GENERAL BACKGROUND

1. GENERAL PROVISIONS

a. The purpose of this agreement is to remedy ensure that prisoners confined to the Mobile County Metro Jail ("MCMJ") are not subjected to unconstitutional conditions of confinement. MCMJ is an integral part of the public safety system. Through the provisions of this agreement, the parties seek to ensure that the conditions respect the rights of prisoners confined there. By ensuring that the conditions are constitutional, the Sheriff and the City will also provide for the safety of staff and promote public safety in the community. The parties agree that the provisions of this Agreement are a reasonable, lawful, and fundamentally fair resolution of this matter.

b. This Agreement shall constitute the entire integrated Agreement of the Parties. Except for the United States' January 15, 2009 Findings Letter and ____ Compliance Letter, no prior drafts or contemporaneous communications, oral or written, shall be relevant or admissible for purposes of determining the meaning of any provisions of this Agreement in this litigation or in any other proceeding.

2. DEFINITIONS

As used in this Settlement Agreement ("Agreement"), the following definitions apply:

a. "Auditable form" or "auditable log" means a discrete record of the relevant information maintained separate and independent of blotters and other forms maintained by the Sheriff.

b. "Cell check" means direct visual observation of prisoners by Mobile County Metro Jail employees.

c. "County" means the government of Mobile County, Alabama, including the County Commission, the Sheriff, the Sheriff's Department, and their agents, officers, and employees.

d. "DOJ" means the United States Department of Justice and its agents and employees.

e. "Effective date" means the day this Agreement is signed by all parties.

f. "Including" means "including, but not limited to."

g. "Implement" means the development and putting into place of a policy or procedure, including the appropriate training of all relevant personnel, and the consistent and verified of that policy or procedure in actual practice.

h. "MCMJ" means the Mobile County Metro Jail, including the main facility located at 450 St. Emanuel Street, Mobile, AL, the minimum security barracks located at 451 St. Emanuel Street, Mobile, AL, and any new facilities used to supplement or replace housing in the Mobile County Metro Jail complex.

i. "Parties" means the DOJ and the County.

j. "Qualified professional" means an individual who is currently licensed, trained, and educated sufficiently to carry out their MCMJ job responsibilities. A "qualified medical professional" is at minimum, a physician or advanced practice nurse, licensed by the State of Alabama. A "qualified mental health professional" is at minimum, a psychiatrist, master's level psychologist, or master's level social worker, licensed to provide mental health services by the State of Alabama.

k. "Sheriff" means the Sheriff of Mobile County, the Mobile County Sheriff's Department, its agents, officers, and employees (both sworn and unsworn).

l. "Serious injury" means any injury that requires immediate medical attention or hospitalization.

m. "Solitary confinement" means confinement in a cell for 23 hours per day.

n. "Staff" includes all correctional officers, employees, or contractors, who have contact with prisoners.

o. "Psychotropic medication" means any medication used to affect mental activity, perception, behavior, or mood.

p. "Prisoner" or "prisoners" is construed broadly to refer to individuals held in custody on behalf of the County, which includes all individuals detained, housed, or confined at MCMJ.

q. "Train" means to instruct in skills to a demonstrated level of proficiency such that a trainee can implement those skills when needed.

II. SUBSTANTIVE PROVISIONS

Consistent with federal law, the County shall provide prisoners with a safe and secure environment, medical care, and mental health care. To achieve this, the County shall take all actions necessary to comply with the substantive provisions of this Agreement listed below.

1. SECURITY AND SUPERVISION

a. The Sheriff shall continue to develop, implement, and maintain appropriate policies and procedures to provide for a reasonably safe and secure environment for prisoners and staff. Security policies and procedures shall be adequate to address: prisoner security classification; prisoner supervision; restraints; and incident reporting.

b. In order to provide adequate security and supervision, the County shall develop and implement an objective prisoner security classification system within one year of the Effective Date. The County shall obtain technical assistance from professional associations, federal agencies, such as the National Institute of Corrections, or other qualified sources, in developing this system. This system shall:

i. Use forms, policies, and procedures for evaluating the security risks posed by or to prisoners. Forms, policies, and procedures shall be based on more than just a prisoner's charge and criminal history. They shall utilize objective, behavior-based criteria, and shall incorporate information about a prisoner's past institutional behavioral history. Objective, behavior-based criteria shall include factors identifying prisoners who are potentially violent, vulnerable, or predatory;

ii. Take into account whether a prisoner has enemies in a housing unit, is involved with a gang, or may participate in a criminal partnership;

iii. Ensure prisoners receive specific housing assignments appropriate for their classification;

iv. Address mental illness, suicidality, disabilities, and special needs;

v. Re-classify prisoners when events require a timely update or modification of the prisoner's classification category. Such events include sentencing for a crime, the loss of a criminal appeal, a disciplinary infraction, or involvement in a serious incident (including prisoner-on-prisoner fights, suicide attempts, or a deterioration in physical or mental condition);

vi. Include an override process to allow a classification officer to occasionally adjust housing assignments based on individual factors, with supervisory approval; and

vii. Include procedures and safeguards to prevent unauthorized staff from re-assigning prisoners to housing units without the prior concurrence or approval of classification staff. This provision is not only to prevent inadvertent violations of security procedures; it is also to prevent prisoners from manipulating staff in order to obtain housing assignments that could facilitate security breaches.

c. In order to ensure sufficient secure, sanitary housing space so that staff can implement security, classification, and housing procedures, the County shall immediately conduct an objective needs assessment.

i. The County shall select and retain an independent, qualified corrections team to conduct the assessment ("the Assessment Team"). The County shall consult with the Monitor and the DOJ on the selection of the Assessment Team. The County will select the Assessment Team, but shall only select an Assessment Team acceptable to the Monitor.

ii. The Assessment Team shall evaluate and identify objective, measurable terms and relevant factors such as the amount of living space required to ensure safe and sanitary conditions, staffing required to ensure adequate supervision and coverage of essential posts (including medical and courtroom transport), and clinical resources required to meet prisoners' serious medical and mental health needs.

iii. The County shall provide updates to the Monitor and the DOJ throughout the process. The County shall provide the Monitor and the DOJ with a copy of the final assessment plan prepared by the Assessment Team. Any plan implemented by the County must meet prisoners' basic need for food, shelter, safety, space, and medical care.

iv. The plan shall describe all short-term remedies, such as double-celling detainees or using contract facilities, as well as long-term remedies, such as new construction or diversion programs, to deal more permanently with overcrowding and anticipated population growth.

v. Any assessment and plan shall include clear timetables, measurable benchmarks, and evaluation of related staffing and funding needs.

vi. Any assessment and plan shall specifically seek to ensure that female prisoners receive equal treatment to male prisoners. This includes comparable housing space, programs, treatment, and activities.

vii. The County shall implement all of the assessment plan recommendations within 18 months of entering into this Agreement. If it is necessary to add housing, the parties anticipate that the County may require a reasonable amount of additional time to complete construction and transition into new facilities. The County shall ensure that any new facilities meet the requirements of federal law and the terms of this Agreement. To that end, the County shall ensure that any new facility complies with American Correctional Association Standards; state and local building or life safety codes; and the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. §§ 12103-12213, its implementing regulations, and any ADA amendments in effect at the time of construction. To the extent professional or state standards exceed minimum constitutional standards, the parties anticipate that the County may not necessarily be compelled to follow those standards exactly, but the County should still consult with the United States before seeking an exemption from otherwise reasonable standards.

d. The County shall continue to take reasonable steps to prevent the unnecessary or excessive use of physical or chemical restraints. The Sheriff shall develop and implement use of restraints policies and procedures that provide for the reasonable safety of staff and prisoners. In particular, the policies and procedures regarding the application of restraints at a minimum shall:

i. Establish clear definitions and distinct criteria for both security and medical restraints;

ii. Require prior written approval of restraint use by a qualified medical professional (or if prior approval is not possible due to exigent circumstances, as soon as is practicable) of the use of restraints for medical purposes, such as protection from self-harm;

iii. Require prior written approval by a supervisor (or if prior approval is not possible due to exigent circumstances, as soon as is practicable) of all uses of restraints for security purposes, other than routine use of restraints for transporting prisoners, such as handcuffing;

iv. Require adequate documentation of the non-routine use of restraints in an auditable log, including the basis for the use of restraints, the performance and results of prisoner welfare checks, and the duration of the use of restraints;

v. Require physician and psychiatrist review and oversight for medical restraint use;

vi. Require adequate periodic welfare checks of the physical condition of all restrained prisoners, to include checks of range of motion, neurological condition, and vital signs, as well as adequate monitoring by qualified medical professionals or registered nurses;

vii. Require coordination and review by mental health staff for all cases in which an prisoner is being frequently restrained, whether the restraints were originally designated by staff as security or medical restraints;

viii. Permit restraints to be used only for security or medical purposes, while prohibiting the use of restraints as punishment or for the convenience of staff. The degree of restraint used should be the minimum required. Security, medical, and mental health staff shall explore, discuss, and implement the range of options that are less restrictive than the restraint bed currently in use (e.g. using de-escalation and communication techniques, behavioral approaches, and less restrictive mechanical restraints). They will make reasonable efforts to use such less restrictive techniques when restraints are required;

viii. Restrict the ability of line officers to unilaterally restrain, lock down, or discipline prisoners. Nothing in this provision is intended to prohibit officers from taking appropriate action to restore order in exigent circumstances, but even such actions must be followed by prompt, medical assessment (including medical and mental health assessment by qualified medical and mental health professionals), supervisory notice, review, and hearing; and

ix. Require videotaping for planned uses of force (e.g. cell extractions). If videotaping is not done, a first-line supervisor must provide a written explanation for why it did not occur.

e. The County shall ensure that correctional staffing and supervision remain sufficient to adequately supervise prisoners, fulfill the terms of this Agreement, and allow for the safe operation of the facility.

f. MCMJ staff shall develop and implement policies and procedures regarding prisoner supervision, including the performance, documentation, and review of routine rounds (cell checks). The policies and procedures regarding prisoner supervision at a minimum shall:

i. Specify categories and criteria for evaluating cell and prisoner conditions;

ii. Continue to provide for rounds on at least an hourly basis for all housing units;

iii. Provide for more intensive supervision when appropriate to address classification, security, or mental health considerations. Such additional levels of supervision shall include rounds every half hour, every quarter hour, and constant direct observation;

iv. Require security staff to document relevant information regarding the performance of rounds in an auditable log that includes time, date, and short description of observations (e.g. whether prisoner was engaged in unusual activity, sleeping, eating);

v. Require that all rounds be conducted at random, irregular intervals;

vi. Continue to provide for documentation and review of frequent, random contraband checks for all units and shifts;

vii. Continue to provide for supervisory audits and review to ensure that staff conduct required rounds;

viii. Establish a systematic procedure for correcting any deficiencies identified in such audits and review of security measures; and

ix. Continue to require adequate investigation, supervisory review, and documentation, on auditable form(s), of serious incidents including uses of force and restraints by MCMJ staff, prisoner-on-prisoner violence, and prisoner-on-staff violence. Supervisory review will include review of use of force incidents by either the warden or an administrative-level designee.

g. MCMJ shall continue working to increase the amount of outdoor exercise made available to prisoners in all units. Prisoners should be given access to outdoor exercise at least 5 times per week for an hour per exercise period, weather permitting.

h. The County shall continue to ensure that sufficient information is collected and documented on serious incidents, restraints, and the use of force to assess whether staff are complying with policy; whether correction, training, or discipline are necessary; whether training and policies are effective; and whether staff practices comply with the Constitution and this Agreement.

i. Documentation on use of force shall include photographs of all visible injuries suffered by prisoners or staff. Injuries shall be photographed promptly after occurrence of the use of force incident.

j. Shift commanders shall review all incident reports within at least 24 hours after an incident. For use of force and restraint incidents, the review shall address specifically whether the report includes all required data (e.g. dates, names, circumstances, weapons deployed, de-escalation techniques used), whether staff complied with policies and procedures, and the substance of the report. Shift commanders will document the results of their review, including any recommended corrective action. Such documentation shall also specifically state findings, conclusions, and recommendations. A higher level administrator will review the package and take appropriate action, including referring incidents for further investigation, follow-up, employment action, or prosecution if necessary.

2. MENTAL HEALTH CARE

a. The County shall continue to ensure that prisoners receive adequate mental health intake, assessment, treatment, and monitoring of their serious mental health needs. MCMJ shall specifically develop and implement policies and procedures regarding prisoner mental health care that provide for chronic mental health care, and improved selection and training for staff assigned to supervise prisoners with special needs.

i. MCMJ shall staff specialized units, including special needs, mental health, segregation, and suicide observation units, with staff specifically assessed for their suitability for assignment to such units.

ii. The process for determining staff suitability shall include mental health department review of candidates being considered for assignment to such units, as well as additional training for staff assigned to such units. Additional training shall include communications training, as well as training on MCMJ policies on the supervision of prisoners with special needs, drug side effects, and indications of increased suicidality or deteriorating condition.

b. The County shall ensure that primary responsibility for supervising special needs prisoners remains with staff, and not other prisoners. The County shall ensure that prisoners serving in any auxiliary health care role, such as the "buddies." are properly screened, trained, and supervised.

c. Medical, mental health, and security staff, including those at a supervisory level, shall regularly meet and communicate to ensure an inter-disciplinary response to

prisoners' special needs. Policies and procedures for this process shall reflect that for special needs prisoners a security issue may actually be related to mental health issues and vice versa; disciplinary sanctions such as isolation are typically clinically inappropriate; and ensuring staff and prisoner safety requires collaboration across departments and shifts.

d. The County shall screen prisoners for mental illness before placing them in solitary confinement. The County shall not place a prisoner with serious mental illness or a developmental disability in solitary confinement in the absence of a qualified mental health professional agreeing to the placement.

e. The County shall continue to update, revise, and supplement its existing policies in order to implement a mental health system that includes a continuum of services, provides adequate mental health staff, ensures development of appropriate written treatment plans, collects quality assurance data, monitors medications and their side effects, provides for clinical review of medication refusals, and includes mechanisms to measure whether care is being provided in a manner consistent with this Agreement and the Constitution. The County shall specifically develop a clearer, more structured, and inter-disciplinary system of care for prisoners with special needs. Policies and procedures, including security policies dealing with suicide risk or special supervision needs, shall use clear and consistent terms (e.g. for the different levels of mental health or suicide observation). Because special needs vary by individual and an individual's chronic condition can fluctuate over time, MCM shall provide assessment, treatment, and services that cover at minimum the following categories:

i. Stable prisoners who are functioning adequately and can be housed safely in general population;

ii. Prisoners who require an intermediate level of structure, supervision, and programming that is not generally available in general population;

iii. Prisoners who are in the most serious or acute condition, requiring the highest levels of supervision and medical interaction;

iv. Prisoners who are awaiting transfer to a psychiatric hospital or other treatment facility; and

v. Prisoners experiencing the effects of drug or alcohol withdrawal.

f. Intoxicated prisoners shall not be moved from booking into other housing areas without a medical assessment.

g. The County shall make reasonable efforts to provide special needs prisoners with equal access to activities and services available to general population prisoners, such as exercise, education, religious ceremonies, and commissary. The County shall not withhold such activities and services solely because an prisoner is housed in special needs cells or units; however, medical and mental health staff may consider an individual's medical assessments, diagnoses, current condition,

and relevant security concerns in determining the appropriate level of access to activities and services.

h. Cells used to house prisoners with special needs shall be sanitary and safe for such the purposes for which they are used. Thus, the County shall continue to improve and retrofit suicide and observation cells to eliminate suicide hazards, such as exposed bars, grates with wide apertures, and protruding fixtures.

III. MONITOR, REPORTING REQUIREMENTS AND RIGHT OF ACCESS

1. Monitor Selection: The parties have jointly selected _____ to serve as the Monitor overseeing implementation of this Agreement. The cost for the Monitor's fees and expenses, including any staff or consultants hired as part of the Monitoring team, shall be borne by the County up to a maximum of $_____/year. The Monitor is responsible for ensuring that any of his or her Monitoring Team members are reimbursed for the cost of their fees and expenses.

2. Monitor Replacement: Should the Monitor position become vacant or if both parties agree that a Monitor should be replaced, they shall confer to select a new Monitor. The County shall be deemed in breach of this Agreement if the parties are unable to come to an agreement on a new Monitor within 90 days of the vacancy.

3. Monitor Qualifications: Anyone serving as Monitor must have appropriate education, training, and experience related to the subject areas covered in this Agreement. The Monitor is responsible for ensuring that any consultants retained by the Monitor to assist with evaluating the County's compliance with this Agreement also have appropriate education, training, and experience.

4. Monitor Ex Parte Communications: The Monitor shall be permitted to initiate and receive ex parte communications with all parties.

5. Monitor's Reports: The Monitor shall submit reports to the parties describing the steps taken by the County to implement this Agreement and evaluating the extent to which the County has complied with each provision. The evaluation shall specifically identify whether the Monitor considers the County to be in substantial, partial, or non-compliance with each substantive provision. The Monitor and his or her team shall describe the factual basis for any findings or recommendations, and shall list documents and interviews relied upon as a basis for their evaluation. The Monitor shall issue an initial report 120 days after the Effective Date of this Agreement, and then every 180 days thereafter. The reports shall be provided to the parties in draft form at least 30 days prior to their issuance. The Monitor shall consider the parties' responses and make appropriate changes, if any, before issuing the report. These reports shall be written with due regard for the privacy requirements of federal law, including the Local Rules for the U.S. District Court – Southern District of Alabama.

6. Limitations and Protections for the Monitor: Except as required or authorized by the terms of this Agreement, law, or agreement of the parties, the Monitor shall not: make any public or press statements (at a conference or otherwise) as to any act or omission of a party related to this Agreement; or disclose any non-public information provided to the Monitor pursuant to this Agreement. Except as required or authorized by the terms of

this Agreement, law, or agreement of the parties, the Monitor shall not testify in any other litigation or proceeding with regard to any act or omission of a party related to this Agreement, nor testify regarding any matter or subject that he or she may have learned as a result of his or her responsibilities under this Agreement. Neither the Monitor, nor any person or entity hired or otherwise retained by the Monitor to assist in carrying out this Agreement, shall be liable for any claim, lawsuit, or demand arising out of their performance pursuant to this Agreement. The preceding provision limiting the Monitor's liability does not apply to any proceeding before a court brought by the County or the DOJ related to performance of contracts or subcontracts for monitoring this Agreement. If the County refuses to reimburse the Monitor as required by this Agreement, the Monitor may seek appropriate judicial relief and may testify to the limited extent required to obtain reimbursement. In the event the Monitor expects to testify in any litigation related to the subject of this Agreement, the Monitor shall timely notify the court of the existence of this Agreement, as well as the County and the DOJ of the pending testimony so that the parties can take appropriate action.

7. The County shall submit quarterly compliance reports to the DOJ and Monitor, the first of which shall be filed within 90 days of the date of this Settlement. Thereafter, the quarterly reports shall be filed fifteen (15) days after the termination of each four-month period thereafter until this Agreement is terminated.

8. Each compliance report shall describe the actions the County has taken during the reporting period to implement this Agreement and shall make specific reference to each specific Agreement provision being implemented. A copy of the Word or Wordperfect version of the compliance report should be sent electronically to the DOJ and Monitor along with an Adobe "pdf" or hard copy of the report.

9. The County shall continue to maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall continue to make such records available to the DOJ and the Monitor at all reasonable times for inspection and copying. In particular, the County shall generate and provide upon reasonable request documents to verify that they have taken actions described in their compliance reports (e.g., census summaries; new policies, procedures, or protocols; new training materials; use of force and incident reports).

10. The Monitor and the DOJ, including its attorneys, employees, agents, consultants, and any other persons authorized by the parties, shall have unrestricted access to MCMJ, MCMJ prisoners, MCMJ staff (including medical contract staff), and documents as reasonably necessary to address issues affected by this Agreement. During the period that this Agreement is in force, the County will specifically provide the DOJ and Monitor with copies of revised MCMJ policies and procedures for review and approval.

11. The County will notify the DOJ and the Monitor within 24 hours of the death of any prisoner. The County shall forward to the DOJ and the Monitor incident reports, medical records, autopsies, death investigation reports (including completed final internal affairs reports), and mortality reports related to such deaths.

12. During the period that this Agreement is in force, the County will specifically provide the DOJ and the Monitor with a copy of revised policies and procedures for review and approval. The DOJ reserves the right to withhold consent to any policies or procedures

that are inconsistent with this Agreement.

13. Within 180 days of the Effective Date, the County will develop and implement Quality Improvement policies and procedures as a means of ensuring self-correction of deficiencies at MCMJ and to track compliance with this Agreement. This self-correction system will identify deficiencies and recommend improvements to practices affecting the life, health, or safety of prisoners and staff. It should include clinical mortality reviews, collection of trend data, an early warning system to identify potential unit or staff problems, and appropriate committees to evaluate and take appropriate action based on the data collected. The County will promptly address problems identified by the ongoing quality improvement process.

14. The County shall retain or assign a Sheriff's Department employee to serve as Compliance Coordinator for the duration of this Agreement. The Compliance Coordinator will serve as a liaison between the Parties and the Monitor and will assist with the County's efforts to attain compliance with this Agreement. At minimum, the Compliance Coordinator will coordinate the County's compliance activities; assist with the County's self-correction and quality assurance process; facilitate the collection of documents and information requested by the DOJ or the Monitor; ensure that MCMJ records are maintained as required by this Agreement; and assist the Sheriff in delegating compliance tasks to MCMJ personnel.

IV. ENFORCEMENT

1. The DOJ shall retain the right to seek appropriate relief from a federal court in the event the County fails to substantially comply with this Agreement.

2. Notice and Cure: Prior to initiating enforcement proceedings, the DOJ shall give the County written notice of its intent to initiate such proceedings, and the parties shall engage in discussions to resolve the dispute. The County shall have 30 days from the date of notice of violations of this Agreement to cure the failure (or such additional time as is both reasonable due to the nature of the issue and as agreed upon by the parties) and provide the DOJ with sufficient proof of its cure. At the end of the 30-day period (or such additional time as is both reasonable due to the nature of the issue and as agreed upon by the parties), in the event that the DOJ determines that the failure has not been cured, the DOJ may initiate proceedings without further notice.

3. In case of an emergency posing an immediate threat to the health or safety of any prisoner or staff member at the Jail, however, the DOJ may omit the notice and cure requirements, and shall have a right to immediate judicial relief.

4. In case the County denies access or otherwise fails to comply with the Monitor, Reporting Compliance, and Right of Access provisions of this Agreement, the DOJ may omit the notice and cure requirements, and shall have a right to immediate judicial relief.

5. Any litigation brought by the DOJ shall be resolved in a federal court of competent jurisdiction pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1345, and 42 U.S.C. § 1997. Venue shall be proper based on 28 U.S.C. § 1391(b).

V. CONSTRUCTION, IMPLEMENTATION, AND TERMINATION

1. The County shall implement all reforms within its areas of responsibility, as designated within the provisions of this Agreement. The implementation of this Agreement will begin immediately upon the Effective Date.

2. Except where otherwise agreed to under a specific provision of this Agreement, the County shall implement all provisions of this Agreement within 180 days of the Effective Date. The terms of this Agreement, and any new policies and procedures developed in response to this Agreement, shall be incorporated into the Jail's training program within 180 days of the Effective Date. All staff shall be trained on this Agreement, and any new policies and procedures developed in response to this Agreement, within 240 days of the Effective Date.

3. This Agreement shall remain in effect until the County has attained substantial compliance with every provision of this Agreement, and then maintained substantial compliance with every provision for a period of one year.

4. The parties anticipate that this Agreement will terminate upon joint agreement of the parties.

5. Failure by any party to enforce this entire Agreement or any part thereof, with respect to any deadline or any other provision herein, shall not be construed as a waiver of its right to enforce other deadlines or provisions of this Agreement.

6. If any unforeseen circumstance occurs that causes a failure to comply with any requirements of this Agreement in a timely manner, the County shall notify the DOJ in writing within five days after the County becomes aware of the unforeseen circumstance and its impact on the County's ability to perform under this Agreement. The notice shall describe the cause of the failure to perform and the measures taken to prevent or minimize the failure. The County shall implement all reasonable measures to avoid or minimize any such failure.

7. This Agreement shall be applicable to, and binding upon, all parties, their officers, agents, employees, assigns, and their successors in office. This Agreement shall apply to both the existing Jail and to any other facility used to replace or supplement housing in MCMJ.

8. Each party shall bear the cost of its own fees, costs, and expenses incurred in connection with this cause.

9. If any provision of this Agreement is declared invalid for any reason by a court of competent jurisdiction, said finding shall not affect the remaining provisions of this Agreement.

10. No person or entity is intended to or shall be a third-party beneficiary of the provisions of this Agreement for purposes of any civil, criminal, or administrative action, and

accordingly, no person or entity may assert any claim or right as a beneficiary or protected class under this Settlement Agreement. This Agreement is not intended to impair or expand the right of any person or organization to seek relief against the County, its elected officials, employees, or agents for their past or future conduct; accordingly, this Agreement does not alter any legal standards governing any such claims, including those under any federal or state law.

FOR THE UNITED STATES:
Respectfully submitted,

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July 15, 2013

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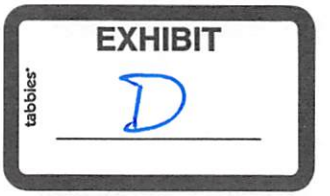

Re: Mobile County, Alabama Metro Jail

Dear Mr. Cheng:

This letter will serve as the Sheriff's initial response to your correspondence of October 18, 2012. We apologize for the delay in getting this response to you.

While this letter will respond to the major issues identified and discussed in your correspondence of October 18, 2012, it is not intended to be a comprehensive response to everything set forth in the "Settlement Agreement" that accompanied your letter. We reserve the right to more fully respond as we continue to work through this process.

We request that this letter be made a part of the administrative record.

The Sheriff and the staff at the Metro Jail have made substantial and continuing efforts to improve the Jail in recent years. This is an on-going effort to which staff have devoted countless hours, and the staff will continue to do what is necessary to make certain that the Jail complies with all constitutional requirements.

Beginning July 1, 2004, the Sheriff contracted with Correctional Medical Services, which later became known as Corizon, to provide comprehensive medical, health, dental, and mental health services to inmates at Metro Jail. CMS/Corizon developed and operated a clinically efficient health care program at Metro Jail that complied with constitutional requirements and with standards promulgated by the National Commission on Correctional Health Care ("NCCHC"). The initial contract with CMS required that the health care services provided by CMS would be designed to meet or exceed the applicable standards developed by the American Correctional

Association and the NCCHC. That original contract further required CMS to obtain NCCHC accreditation of the Metro Jail's health care program within eighteen (18) months.

Metro Jail's health care program was accredited by NCCHC in June 2006, and that accreditation has been maintained through the present date. As you know, the process to maintain accreditation involves inspections and audits of the health care program by trained professionals. Through the accreditation process, NCCHC renders a professional judgment on the effectiveness of a correctional facility's health services delivery system. We are proud that Metro Jail's health care program has maintained accreditation continuously for the past seven (7) years.

While CMS/Corizon did a great job of developing and operating the Metro Jail's health care system for the past nine (9) years, through our continuing auditing of the system it became evident that a change in health care providers was necessary. Thus, beginning in November 2012, Metro Jail and Sheriff's Office staff began an arduous process of soliciting and reviewing proposals to operate Metro Jail's health care delivery system. Through this competitive process, NaphCare, Inc. ("NaphCare") was selected to operate Metro Jail's health care delivery system beginning July 1, 2013. We entered into a comprehensive contract with NaphCare, and a copy of that contract is enclosed as Exhibit "A" for your review.

The contract requires that NaphCare meet or exceed the standards developed by the American Correctional Association and the NCCHC, and requires that NaphCare maintain NCCHC accreditation. As set forth in the contract, the failure of NaphCare to maintain NCCHC accreditation shall constitute a material breach of the contract. [Health Services Agreement at ¶ 3.1].

NaphCare's staffing plan is attached to the contract. As you can see, NaphCare is staffing the docket/intake area with a Registered Nurse (RN) seven days per week. Incoming inmates will receive a medical and mental health screen at intake. NaphCare's receiving screening process is described in the documents attached as Exhibit "B".

One of the issues identified in your correspondence of October 18, 2012, concerns electronic medical records. NaphCare has assured us that it has a state of the art electronic medical record system. The contract requires that this electronic medical record system be fully functional no later than September 1, 2013. As set forth in the contract, the failure to have the system fully functional by that date shall constitute a material breach of the contract and subjects NaphCare to a daily penalty for each day that the system is not functional after September 1, 2013. [Health Services Agreement at ¶ 5.1].

NaphCare has read your correspondence of October 18, 2013, and has assured the Sheriff and his staff that it understands that it is a priority for the Sheriff's Office to

be fully compliant and to address the issues identified therein. NaphCare's comprehensive program provides healthcare policies and procedures that will ensure compliance in the areas detailed in your correspondence. We are confident that NaphCare's policies and procedures, and the healthcare that NaphCare provides to inmates at the Metro Jail, will be fully compliant with all constitutional requirements as well as the standards promulgated by NCCHC. We are also confident that our continued monitoring of healthcare services, by NCCHC through the accreditation and re-accreditation process and by periodic inspections and audits conducted by our expert consultant and monitor Jackie Moore, will ensure full compliance with the applicable and required standards.

The following addresses the particular issues of need and outlines plans to ensure full compliance with the applicable and required standards:

Medical Care Issues

1. Deficient Classification and Housing Assignments

NaphCare's electronic health record system, *TechCare*, efficiently tracks an inmate's location within the jail–from cell to cell, floor to floor, or wherever the inmate is currently housed–while keeping all updates to the health record available for medical staff.

Using *TechCare*, medical staff can work with correctional staff to electronically flag inmates' medical records to designate their housing location based on their level of dangerousness or other needs for segregation, such as a gang membership. This helps track inmates and provides instant access to housing information and segregation designations to ensure their proper housing placement at all times.

Inmates will be flagged upon intake based on information received during the receiving screening. NaphCare will implement a standard, systematic process for obtaining the necessary information in order to properly classify inmates and place them in housing that ensures the safest outcome.

2. Quality Assurance

NaphCare possesses a correctional electronic medical records system with the capabilities and customization to fit Metro Jail's needs for quality assurance. *TechCare* is a valuable tool in ensuring quality assurance, contract compliance, and the timely performance of standard medical protocols in the correctional setting. NaphCare practices complete transparency in its operations, and will share all data that is utilized to track medical care and manage risk. The reports that NaphCare currently uses track data that is necessary for statistical analysis required by the NCCHC and the ACA.

This data is presented on a daily basis and summarized on a weekly and monthly basis for accurate yearly reporting.

NaphCare's quality assurance program is further defined and explained in the pages attached as Exhibit "C".

NaphCare has agreed to give our contract monitor, Jackie Moore, access to the TechCare system to enable her to monitor compliance.

3. Internal Management

TechCare is an electronic medical records system that can customize reports based on Metro Jail's specific contract compliance measures. NaphCare will submit statistical daily reports pertaining to medical services rendered, and a monthly contract compliance report to the Contract Monitor, administrators, and/or their designees, to assist management with the efficient and direct correlation of contract compliance indicators. NaphCare staff is able to mine data from within *TechCare*, which means every piece of information entered is retrievable and can be quantified.

- **Monitoring nurse-driven health assessments**

  All nursing assessments are tracked for completeness, timeliness, and suitability of care. Each assessment is reviewed by a practitioner. For example, a patient that may have missed his or her receiving screening for any reason (i.e.,behavioral) will automatically be placed on *TechCare's* missed receiving screening report, which is sent directly to the Charge Nurse for review and follow-up.

- **Medication administration**

  All prescribed medications are tracked electronically within the eMAR module in *TechCare*. If a patient misses a prescribed medication pass for any reason (i.e., a module move or court appearance) they are automatically placed on *TechCare's* missed medication report and the medications are provided immediately.

- **Improve documentation on follow-up after off-site visits**

  NaphCare has developed Quality Assurance Modules in *TechCare* that trigger when a person is sent off-site for scheduled chronic care visits or non-scheduled emergency visits. NaphCare has a dedicated team of case managers at its corporate office that track each of the patient's care and ensure that their follow-up documentation is placed into their electronic health record. NaphCare also requires that any patients

returning from a scheduled or non-scheduled off-site visit receive follow-up by a practitioner within 24 hours. Proactive quality assurance initiatives within the *TechCare* system ensure that this follow-up is scheduled and performed on time.

Mental Health Care Issues

1. Improper Use of Restraints on Inmates with Mental Illness

Naphcare's policy and procedures follow NCCHC standards for therapeutic restraint utilization, but both NaphCare and Metro Jail staff understand the need for communication and continued discussion between custody and clinical staff to ensure full compliance in the use of restraints. The utilization of restraints and seclusion will be an ongoing agenda item in the Medical Audit Committee (MAC) meetings to ensure policy compliance and clear communication between custody and NaphCare medical and mental health staff. Additionally, a CQI study on the utilization of restraints and seclusion will be conducted, at a minimum, annually.

NaphCare's policy on restraints and seclusion is attached as Exhibit "D". Metro Jail staff is in the process of working with NaphCare's personnel to develop and implement internal policies to ensure full compliance in this area. This process will include a review, and revision as necessary, of Metro Jail's policies and procedures that impact this area.

2. Improper Placement Decisions for Inmates with Mental Illness

NaphCare utilizes segregation and performs rounds on segregated inmates in accordance with NCCHC policy J-E-06. In doing so, NaphCare proactively identifies inmates at risk for suicide and decompensation.

By screening all inmates on day one of incarceration, NaphCare can identify those with a serious mental illness and work with custody for appropriate placement at that time. Thereby being proactive in ensuring inmates have an appropriate housing assignment.

NaphCare is accessible 24/7 to assist with any special housing assignments. The utilization of inmate housing will be an ongoing agenda item in the MAC meetings to ensure policy compliance and clear communication between correctional staff and NaphCare medical/mental health staff.

Metro Jail staff is in the process of working with NaphCare's personnel to develop and implement internal policies to ensure full compliance in this area.

3. Absence of Clear Procedures for Transitioning Inmates with Mental Illness to Less Restrictive Settings

NaphCare, in conjunction with correctional staff, will establish a step down unit for inmates who are no longer acutely suicidal but have yet to achieve and maintain the level of stability required to be returned to the general population. Criteria will be established for both admission and discharge from the step down unit based on specific clinical and behavioral criteria to include the following:

a. Consistent absence of self injurious behavior or threats;

b. Consistent compliance with prescribed medications and other therapeutic interventions;

c. Upkeep of personal hygiene and living area;

d. Consistent compliance with facility rules and regulations;

e. Approval of admission/transfer following evaluation by a licensed mental health professional.

NaphCare mental health professionals will provide, at a minimum, five hours of structured group therapy utilizing recognized best-practice curriculums to include the following:

- Beyond Trauma Curriculum: A Health Journey for Women - Stephanie Covington, Hazelden Publishing;

- Living in Balance with Co-occurring Disorders - Hazelden Publishing

NaphCare mental health staff will also ensure there is consistent and frequent communication with custody staff focused on the development of a unified team dedicated towards inmate safety.

4. Inadequate Training for Security Staff

NaphCare's Assistant Vice President of Mental Health Operations, Bill Kissel, is an active Crisis Intervention Team (CIT) instructor, and we expect that he will implement programs and policies to ensure that focused, relevant, and current training opportunities are in place at the Mobile County Metro Jail. Metro Jail has been advised that Mr. Kissel is available to provide any requested training and to assist in the identification and management of inmates with serious mental illness, and Metro Jail staff will work with him to take advantage of this training opportunity.

Mr. Kissel has developed training curriculums for mental health topics including Suicide Prevention, Mental Health Awareness, and Crisis Intervention. He frequently provides training on these topics at NCCHC, ACA, and AJA conferences. These established curriculums are available and ready for implementation at the Mobile County Metro Jail. Metro Jail staff is in the process of working with Mr. Kissel and NaphCare's personnel to develop and implement internal policies to ensure full compliance in this area.

Additionally, NaphCare provides suicide prevention training to all on-site correctional and medical staff employees who regularly interact with inmates. NaphCare staff undergoes an 8-hour initial training that includes the following topics:

- Signs and symptoms of predisposing factors of potentially suicidal inmates;
- Risk factors in the evaluation of suicide potential;
- Management of suicidal inmates;
- Review of institutional procedures regarding suicide prevention.

NaphCare will provide annual updates and additional training to keep all staff aware of changes in suicide policies and to update staff on the latest advances in the care of suicidal inmates. NaphCare and the staff at Metro Jail believe collaboration among medical, mental health, and correctional staff is imperative in successful suicide prevention, and we will work with NaphCare and all of Metro Jail's partners to provide training that complies with NCCHC and ACA standards.

5. Excessive Reliance on a "Buddy System"

NaphCare has decided that it will not depend upon and will not implement the buddy system as part of its program.

Since NaphCare has just recently taken over operations at Metro Jail, we are in the process of finalizing changes in procedures and have not yet determined if Metro Jail will continue to use the "buddy system" as a sort of back-up for monitoring inmates. NaphCare has pledged that if Metro Jail desires to continue use of this system, then NaphCare will implement appropriate screening, training, and oversight in the use of the buddy system to eliminate the problems and concerns identified in your letter of October 12, 2012.

I suspect that Metro Jail will cease to utilize the "buddy system," and will let you know what the final decision is.

6. Problems Relating to Supervision of Suicidal Inmates

NaphCare's suicide policy ensures that suicidal inmates are seen, at a minimum, once a day by a mental health staff member. All encounters are documented in the inmate's electronic health record, specifically, within the *TechCare* Suicide Care Plan, which ensures medical and mental health leadership is able to monitor mental health staff's encounters and documentation of supervision of suicidal inmates.

Documentation will exist for observation by custody officers, medical staff, and mental health staff. NaphCare will make sure that the level of supervision matches the level of need. Additionally, NaphCare will coordinate with custody staff to ensure inmate safety and utilize security resources in the most efficient manner.

The supervision of suicidal inmates will be an ongoing agenda item in the Medical Audit Committee (MAC) meetings to ensure compliance and clear communication between custody and NaphCare medical and mental health staff. Additionally, a CQI study will be conducted, at a minimum, annually.

7. Failure to Clearly Define Terms in Policies Relating to Mental Health Care

NaphCare's mental health policies meet or exceed NCCHC and ACA standards, are consistent, and bring standardization to mental health operations. The use of *TechCare* provides standardization of all forms and policies to ensure quality patient care.

NaphCare will ensure that the clinical staff is educated on applicable policies and procedures for care. NaphCare will provide routine updates and training on all policies and procedures to medical and mental health staff and such information sharing is documented and available for inspection. Each new staff member receives orientation to all health-related policies and procedures, and documentation is maintained in the employee's personnel and training files. Policy manuals are available to all medical and mental health staff, independent contractors, or subcontractors at all times in an accessible area in the health services unit. Clinical staff can also access NaphCare's policy and procedure manual online to obtain important information 24 hours a day, seven days a week.

Mental Health CQI

NaphCare will implement an aggressive CQI program with the Mobile County mental health program. NaphCare will conduct regular studies, identify opportunities for improvement, and develop effective corrective action plans to ensure all areas of mental health care are compliant with correctional standards. Ongoing improvement activities will focus on patient care areas to include:

- Timely mental health screening
- Effectiveness of the referral process
- Timely psychiatric evaluation
- Suicide policy compliance
- Medical services provided for those on medical confinement status
- Discharge planning
- Emergency mental health response
- Involuntary medication administration

Protection from Assaults

We disagree with your conclusion that Metro Jail has an unacceptably high rate of inmate-on-inmate assaults, but we will address the three areas of concern that you identified.

1. **Deficient Classification and Housing Assignments**

We agree with you that a properly designed and functional classification system is one of the foundations for safe jail operations. Of course, any classification system is oftentimes limited and constrained by the physical facilities, and that is certainly the case with Metro Jail.

Metro Jail is in the process of implementing an improved objective classification system. Under that system, classification will begin at point of entry into the jail in the docket area.

Metro Jail will continue to address the Jail's classification system and policies, and welcomes any concrete suggestions that you may have to offer.

2. Overcrowding

Staff continues to proactively address the Jail's population by working with the district attorney, the local judiciary, and other outside agencies such as community corrections. Jail administrative staff have met with the County Commissioners to discuss facility requirements and the need for additional housing space.

In addition, a renewed emphasis is being placed on observation by increasing the number of correctional officers assigned to work in the housing areas.

We welcome any concrete suggestions you may have to offer on this issue.

3. Deficient Use of Force Monitoring by Video

We disagree with your conclusion that "the failure to appropriately video staff's use of force will inevitably lead to the unauthorized or excessive use of force as a tactic for handling disruptive inmates." A video monitoring program may be what you refer to as a "best practice", but requiring such a program is (1) beyond the requirements of any constitutional standard and (2) not warranted by past history or practices at Metro Jail.

We will continue to address the issues identified in your letter of October 12, 2012, and Metro Jail staff is in the process of working with NaphCare to develop and implement policies and procedures as noted herein.

Of course, please call me at any time if you have any specific questions or issues that you wish to address.

With highest regards, I remain,

Very truly yours,

James B. Rossler

U.S. Department of Justice
Civil Rights Division

Rec'd 8-12-13

JS:AS:CNC:EB:pjc
DJ 168-3-38

Special Litigation Section - PHB
950 Pennsylvania Ave, NW
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August 6, 2013

BY FIRST CLASS AND ELECTRONIC MAIL

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Dear Counsel:

Thank you for your July 15, 2013 letter. Your letter detailed some encouraging developments at the Jail. We write now to offer some recommendations and to propose next steps.

First, in principle, the broad remedies described in your letter should address many of our concerns, but the details of Naphcare's implementation process are critical.

We therefore recommend that your clients and Naphcare reference our recent correspondence during the implementation process. In regards to mental health care, we suggest they give particular attention to our proposed settlement agreement. Although your clients have not entered into a formal agreement, our draft settlement offers a detailed framework to bring Mobile County's mental health system into compliance with federal standards. For instance, our settlement identifies different categories of treatment and safeguards for the use of restraints.

We also recommend that Naphcare staff use our recent correspondence not just to identify remaining deficiencies, but also to identify problem areas that may have only recently been addressed. In the push to fix any remaining problems, Naphcare should be careful not to undo past remedies. Naphcare will be implementing significant changes to how staff enter appointments, document treatment, order labs, track medications, manage chronic care, and make referrals. These are all issues that have only recently been fixed, or which have been fixed

only partially. Naphcare's new systems may resolve all remaining problems, but they could also inadvertently exacerbate or revive dormant ones. To ensure a more positive outcome, Naphcare staff should therefore inform themselves as to the general history of this case, even as they focus on what still needs to be done.

Second, we would like to schedule a phone conference with you, and your clients, to discuss next steps. Specifically, we would like to discuss several issues that were not fully addressed by your correspondence. These include - a) incorporating the proposed remedies into a signed agreement that more specifically identifies timeframes and requirements for closing out this matter, 2) developing a more detailed plan to address long-term crowding, 3) discussing the county's objections to incorporating videotaping in the use-of force policies.

We propose that the phone conference take place during the weeks of August 19th or 26th. We anticipate that the conference will last no longer than 2 hours. If any dates work for you, please let me know as soon as possible. If you had already planned to write to us about the issues that we plan to raise during our phone conference, please let us know your timeframe. For instance, we assumed from your silence that you did not intend to specifically respond to our draft settlement agreement. If we were mistaken, let us know, and we can discuss schedules accordingly.

Thank you again for your thoughtful response to our most recent compliance letter. We look forward to working with you to move this matter forward.

Sincerely,

Christopher N. Chong
Attorney
Special Litigation Section

U.S. Department of Justice
Civil Rights Division

SHR:LC:CNC:AN:pc
DJ 168-3-38

Special Litigation Section - PHB
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April 22, 2016

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Mobile, AL 36602

Jay Ross, Esq.
County Counsel
Mobile County Commission
205 Government Street
Mobile, AL 36644

RE: Mobile County Metro Jail

Dear Counsel:

We have completed our review of the policies, procedures, and corrective action documentation, sent by the County from early 2015 through November 5, 2015, in response to our March 2, 2015 correspondence. As discussed, we are prepared to have our consultants discuss their recommendations with your staff as part of the ongoing technical assistance and inspection process. We also write, however, to provide you and your clients with a summary of our recommendations and concerns.

Our review focused on continuing concerns identified in our compliance assessment letters. We carefully evaluated documents that the County submitted to demonstrate remedial action, or to demonstrate that no continuing deficiencies exist. These documents included policies, training records, population data, and logs.

I. Medical Care

We have four concerns with the Jail's medical policies regarding assessments, quality assurance, mortality reviews, and training. Our consultant also raised some questions about the policies, which we do not believe arise to a level of concern at this time. We ask that the County address the questions, however, because they do identify potentially serious issues with the County's ongoing remedial efforts.

First, the Jail policy for health assessments is unclear, and allows a potentially dangerous delay in obtaining a medical assessment for new prisoners. The security policy indicates that

new prisoners should get a health assessment upon arrival, but if it cannot be completed, then the staff can wait up to 14 days. This policy appears to conflate the intake/booking screening with the 14-day health assessment. The 14-day health assessment is not a substitute for initial screening. For instance, a prisoner who enters the facility while suffering from psychosis or severe drug withdrawal cannot wait 14 days for a medical assessment. We recognize that staff may not be able to get coherent answers from a prisoner when trying to conduct an intake screen. But the policy should not imply that staff may then wait before doing an assessment.[1]

Second, we commend the County for implementing medical quality assurance mechanisms, but note that the County's data suggests continued non-compliance with some critical medical policies on suicide/mental health, restraints, and detoxification. These are all areas that we have previously identified as significant deficiencies. For instance, staff are still not consistently monitoring patients in restraints; and the physicians are still not consistently issuing appropriate orders pursuant to detoxification protocols.[2] It was unclear whether the County took corrective action, such as staff-retraining, to address the quality assurance study results.

Third, the County's mortality review process remains problematic. The County provided a mortality review for a prisoner who died in the past year. The review itself was limited, and no medical records were attached to the review. The omission is worrisome. A mortality review is more than just an autopsy or criminal review. It serves as an internal clinical review as well. Without documentation from the medical chart, the reviewer cannot examine timelines, staff performance, policy compliance, and other details that may reveal the need for re-training or other corrective action. As with quality assurance, the County needs better documentation of analysis and follow-up when conducting internal administrative reviews.

Fourth, we evaluated Jail training records and found limited, but significant, gaps in the program. The County training materials are useful and address important topics (e.g. mental health care and segregation). However, we noted discrepancies between the training materials and documentation offered to confirm that the staff has actually been trained on those materials. For instance, the training records do not show which staff, if any, actually attended the otherwise comprehensive PowerPoint presentations provided in the County's document production. There

[1] We suspect that the County may have intended that the 14-day rule serve as a fallback or safeguard. If staff could not complete the intake screen at intake, they still had to finish it at the 14-day health assessment. We can discuss rewording the policy to incorporate the County's intentions. Our concern is that staff might mistake the policy as a waiver i.e. If a prisoner cannot be screened at intake, the staff can just wait. The Jail has had incidents where such delays occurred, and therefore policies should require more proactive staff responses to medical situations.

[2] We have previously advised that medical staffing is generally acceptable, but that in practice, prisoners may not be getting necessary treatment because of problems in the way the system is organized. We have not evaluated this issue on-site, but the data provided suggests that it remains a concern. As noted elsewhere in this letter, the security and medical departments are still not well integrated. This type of systemic issue can contribute to the types of deficiency identified by the quality assurance reports. For instance, if security staff place an intoxicated prisoner in a detoxification cell, but fail to notify medical staff, the physician will never know that a patient needs treatment. Alternatively, if nursing staff treat the prisoner but do not comply with Jail protocols, the physician may again be left out of the loop. The physician could also be responsible for the problem, if for instance, the physician is simply not writing orders. Administratively, the Sheriff and medical provider need to assess the source of the problem and take coordinated corrective actions.

was also no documentation that nurses, physicians, or physician assistants attended the suicide training.

Finally, the documents raised several additional questions the County should address. Otherwise, the material provided is not itself sufficient to demonstrate compliance with federal standards. For instance:

- Why are there still no policies clearly mandating medical follow-up after the use of force? We have previously noted that the Jail does not have all of the necessary checks and balances required to prevent misuse of force. The County expressly declined to require videotaping of planned uses of force (e.g. when a response team attempts to remove a mentally ill prisoner from their cell). This decision was itself problematic. The additional failure to require medical follow-up for anyone subjected to OC spray or tasers is further evidence of a risky approach to use of force in the Jail.[3]
- Why is there no specific mechanism in the policies for how security staff notifies medical staff when placing a prisoner (e.g. an intoxicated or mentally ill special needs prisoner) into segregation?[4] For instance, if security staff place an intoxicated prisoner in segregation, the segregation and medical policies need to be consistent about what happens next. The security staff should immediately notify their point of contact in the medical unit. Similarly, security staff should not be removing persons placed in segregation for medical reasons without a medical clearance. While security staff may need some flexibility in putting special needs prisoners in segregation, the current policy is vague, and actual practice is clinically problematic and often unsafe. So it is important to have close coordination between medical and security staff, which is not something required by the Jail's current policies.
- Are observation policies being implemented or only in draft form? The policies include forms for safety and welfare checks. But in its document production, the County provided what appear to be excerpts from unit logs. These are inadequate and quite different from the forms in the policies.

II. Security

As with medical care, the provided documentation indicates some effort to improve security policies and practices. However, three of the most serious problems from past tours persist.

[3] Use of force policies require staff to be alert for medical issues after use of force, and medical staff are involved in removing taser prongs. But the policies are ambiguous about medical assessment and treatment. Similarly, the segregation policy suggests medical assessments may occur after a physical confrontation, but the decision on when to notify medical staff is again vaguely written and left to the discretion of low level staff.

[4] Security staff are not trained or qualified to medically assess someone who may be injured or require mental health intervention. We appreciate that the County needs to triage needs or requests for medical care, but any mechanism used for this purpose may not facilitate abuse or deny access to necessary care. Security staff must not be able to impede access after critical incidents, such as a use of force, by sending prisoners to segregation without an opportunity for care. Such practices circumvent the more appropriate clinical screening mechanisms already incorporated in the medical policies.

First, use of force, restraint, and segregation policies remain inconsistent, weak, and confusing. See e.g. Policies 32g, 35d. For instance, there are inconsistencies in the security policies in regards to what must happen when a prisoner is injured. Some policies suggest security staff should screen the prisoner to determine whether medical attention may be required. Others do not. These deficiencies are similar to the ones described in the Medical section above, which suggest that either a) security plays too much of a gatekeeper role in denying prisoners access to medical care, or b) there is a lack of integration between the security and medical departments. Other problems with these policies include:

- The policies do not describe limits on the use of restraints, such as who may order restraints, how long a prisoner may be held in restraints, or who may release a prisoner from restraints.
- The security policies require range-of-motion breaks every 3 hours, but the medical policies required them every 2 hours.
- The provider's policy on stripping suicidal or mentally ill prisoners is more humane and clinically appropriate than the security policy. Generally, the medical policies for such matters were better written than the parallel security policies.
- The Taser, OC spray, and segregation policies are not consistent in terms of when medical staff must be notified after a use of force.[5]
- The use of force review policy requires the Deputy Director to review materials, but does not require documented findings, such as a finding that the officer complied with policy or a recommendation to refer the incident for review by internal affairs.
- There is inadequate accommodation of persons who cannot read or write (including those for whom English is a second language).
- Grievance review procedures do not prioritize emergency grievances (e.g. a prisoner who grieves about unaddressed chest pain must wait the same number of days for a response as a prisoner who missed commissary).
- There are restrictions on access to materials from defense attorneys for prisoners in the disciplinary wedge.

In general, the security policies could benefit from updating and legal review. As written, many of them may actually promote unlawful staff conduct or demonstrate administrative approval of unconstitutional conduct. We also note the security policies are undated, which suggests they are only drafts

Second, we remain concerned about overcrowding of female prisoners. In addition, female prisoners are all placed in the same housing unit despite significant differences in classification or security status. The County has not provided any detailed response as to how it has, or will, handle the supervision and sanitation issues associated with the crowding problem.

[5] The policy (V.L.3) on taser electronic record audits also does not describe specifically when such audits should occur, only that they occur "periodically." As with the medical notification policy, the security staff allow themselves a great deal of discretion in when they actually need to comply with the safeguards built into those policies. It is much too easy for security staff to ignore all the procedures designed to serve as a check and balance on the use of force, and still remain in compliance with Jail policies.

Third, the housing assignment process still does not clearly comply with sound classification principles. Although the Jail uses a classification form, the housing assignments are apparently still done in a crude and potentially dangerous manner. For instance, most of the women are housed together, with little effort to separate individuals based on classification factors (e.g. known enemies). More generally, the County continues to designate housing units by charges, even though a prisoner's classification risk may not equate to their current charges (e.g. a prisoner with a history of institutional violence may be in the Jail only for a minor charge, but should still be placed in a more secure area). The Jail classification policy also has some significant omissions. For instance, there is no procedure for over-rides. It does not even have a classification scale. In other words, after classification staff score a prisoner based on risk factors, they should be using the scale to help identify where the prisoner should be housed (e.g. a classification score of 0-4 would be considered "minimum" and 5-8 would be "medium").

We recognize that it is possible that the County has actually done more to implement reforms than indicated in the records. We also are not suggesting that all conditions in the Jail violate minimum standards. Indeed, we have previously noted that the concerns revealed by our review are fairly limited. However, our concerns are serious ones, and the County has had ample time to implement remedies. Yet, the County has not done so, even for critical areas such as classification, which could have been improved without significant costs. While we would prefer giving the County the continued opportunity to voluntarily remedy any issues, we believe that more needs to be done promptly to address the ongoing deficiencies at the Jail.

We anticipate that the County will respond in good faith to this letter by taking necessary action within the next three months. Perhaps the County should consider reviewing its policies with a consultant. We again invite the County to consult with our office as it implements any additional remedies.[6] If you have any questions, please feel free to call me directly at (202) 514-8892. Otherwise, I will be calling you shortly to discuss next steps.

Sincerely,

Christopher N. Cheng
Attorney
Special Litigation Section

cc: Sheriff Sam Cochran
Mobile County

[6] The County has not been responsive to similar invitations in the past. We note that these cases move much more quickly to closure when local officials incorporate technical assistance and respond to our recommendations. Ignoring some of those recommendations can be as harmful to the safety of staff and the community, as to the prisoners. For instance, unsound housing, supervision and classification systems lead to violence and tensions already exacerbated by crowded, institutional conditions and can also reinforce gang activity, contraband, and other illicit behavior.

The NATIONAL INSTITUTE for JAIL OPERATIONS

MOBILE COUNTY SHERIFF'S OFFICE

Mobile County Metro Jail Assessment Report of Findings

28 September 2015

Mobile, AL

AUDIT TEAM

Todd Davis, CJE

Tate McCotter, CJE

INDEX

BACKGROUND

The National Institute for Jail Operations (NIJO) provides resources for sheriffs to make jails safer, more secure and protect against liability and adverse publicity. Services provided by NIJO include the creation and maintenance of legal-based guidelines specific to states and circuit courts, comprehensive staff jail training, complete jail inspections, case expert testimony, audit and accreditation services, and model policy development.

In Alabama, NIJO has worked with the Alabama Sheriffs' Association (ASA) and the Association of County Commissioners of Alabama (ACCA) to provide legal-based resources, including the creation and management of the Alabama Jail Training Academy (AJTA) and the Alabama Legal-Based Jail Guidelines, currently used by over 30 jails in Alabama. Additionally, NIJO has been contracted by numerous facilities since 2011 to conduct various verification inspections, assessments and audits of jails, operations, policies and training.

SCOPE OF WORK

When founded upon legal-based guidelines, jail inspections can be very proactive means for sheriffs and jail administrators to discover and measure how their physical facility, policies, procedures and operations compare to what the law requires to run a constitutional jail. Far too often, jails have limited resources that, over time, have produced outdated facilities that can compromise safety, security and control. Often the physical structures have resulted in management modifying policies and procedures to accommodate the structure and staffing but fail to adhere to what the respective federal, Circuit Court and state statutes require. Many sheriffs use verification inspections as a means to ascertain whether their jail administration, operations, practices, procedures and training reflect those things required by the law. NIJO encourages "inside-out" methodology for inspections whenever possible using the NIJO Legal-Based Jail Guidelines to keep the inspection focused on primary issues of safety, security and administration while mitigating the subjectivity of the inspectors. This eliminates a "gotcha" mentality that is often associated with external audits and inspections.

The National Institute for Jail Operations (NIJO) was contacted by Mobile County requesting an assessment of the Mobile County Metro Jail to help address liability concerns, physical plant issues, and how operations is impacted due to physical restraints and may be impacted by future jail population growth.

A contract was drafted which outlined task and deliverables to be addressed by NIJO. The county contracted with NIJO staff Tate McCotter and Todd Davis and a schedule was established for NIJO to make a site visit to the Metro Jail on the 12th and 13th of August 2015.

Tate McCotter and Todd Davis arrived at the Metro Jail at approximately 0830am on the 12th of August, 2015 and met with Warden Oliver. Deputy Warden Houston, Captain Stallworth,

Captain Prince and Lieutenant Love as well as Tyler Martin, P.E. from the county engineering department to establish the protocol for the facility tour, current concerns, and other pressing issues related to the facility.

After the initial interview, Warden Oliver directed Captain Stallworth and Lieutenant Love to escort NIJO staff on a walk- through of the Metro Jail. After the briefing and introductions of the command staff, a general tour of the facility was conducted. This began the onsite field verification of the jail, which concluded August 13th at 1420pm.

The objectives of the operational assessment were as follows:

- Review the physical facility and overall operations to determine recommendations on addressing key issues dealing with the inmate population, movement, safety and security from a legal-based perspective.
- Generally review policy and procedure to ascertain whether staffing is adequate to meet constitutionally based requirements.
- Provide a written report with recommendations and options to address findings during the onsite inspection.

METHODOLOGY

NIJO inspectors are qualified and trained to conduct thorough inspections; however, on-site inspections are a snapshot in time and are meant to provide an unbiased verification of the policy and procedure, conditions of the physical facility on the date and time they were inspected. Careful consideration is given to inspect areas that are of greatest concern and high liability risk as dictated by the organization requesting the inspection. NIJO inspectors asked permission of the sheriff to access the jail, housing, booking, medical, laundry, kitchen, recreation, programming areas, etc. Interviews with various staff members were very useful in gathering information regarding the physical facility limitations related to day to day inmate movement and activity.

As applicable to the scope of this project, NIJO inspectors reviewed policy and procedure prior to the on-site inspection. NIJO requested the Sheriff's Office to send a copy of policy and procedure, staffing, post orders, physical facility layout maps, and other documentation in advance so inspectors were familiar with the general layout, basic operations, duties and POST orders. Inspectors only verified information pertinent to the scope of the project.

The inspectors were on-site at various times during shifts to measure consistencies in following policy and procedure. Also, certain administrative operations were better measured at certain times of day, such as access to and observation of medical facilities, booking and intake, inmate programs, visitation, perimeter security, etc.

NIJO inspectors observed the physical facility and its design/ layout, capacity, inmate movement, service times, visitation, facility inspection, court transportation security/routes, inmate intake procedures, and a specific inspection of the facility to complete the review and assessment analysis. NIJO also completed a general review of officer posts, inmate disciplinary infractions, major incident reviews, inmate grievances, staff recruitment and retention information, recent inspection reports and other information provided by the Mobile County Metro Jail administration as they might be related to the physical facility and objectives outlined in the Scope of Work.

Upon completion of the on-site inspection, NIJO was asked to provide the Sheriff and key personnel involved with the project a detailed, written report of the inspection addressing the core objectives of the inspection, verification results and recommendations. Results of this request and recommendations are contained herein. If extensive follow-up is needed, such as staff training, assistance with policies and procedures, facility design or remodel consultation, technical assistance, or a secondary verification inspection, such requests will be conducted separately, unless otherwise negotiated.

JAIL FACILITY ONSITE OBSERVATIONS AND FINDINGS

NATIONAL INSTITUTE FOR JAIL OPERATIONS
PHYSICAL FACILITY OPS ANALYSIS

FACILITY IDENTIFICATION

Name of Facility: MOBILE COUNTY METRO JAIL
Facility Type: PRE-TRIAL DETAINEES

Mailing Address: 450/451 ST EMANUEL ST. MOBILE AL 36603
City: MOBILE County: MOBILE Phone: 251-5744702
Sheriff: SAM COCHRAN Facility Administrator: NOAH "TREY" OLIVER

County Commissioners: COMMISSIONER PRESIDENT JERRY CARL COMMISSIONER VICE-PRESIDENT MERCERIA LUDGOOD, AND COMMISSIONER CONNIE HUDSON

Date and time of last inspection: MAY 17, 2014

Inspector(s) and agency: MOBILE COUNTY METRO JAIL'S WARDEN N. OLIVER, DEPUTY WARDEN, R. HOUSTON, CAPTAIN SADIE STALLWORTH, CAPTAIN FELICIA PRINCE, AND LIEUTENANT ANTHONY LOVE .

Population on date of inspection: 1.335
Date of Last Inspection: May 17, 2014

Provide a detailed response of problems experienced with the facility operations in the past year.
Maintenance issues in the kitchen, security housing, central control, operating system, heating, A/C issues, plumbing, infrastructure, space challenges in intake, clinic and housing, etc.

Health Inspection: Yes — Date of Last inspection: JULY 2015
Boiler Inspection: Yes — Date of Last Inspection: June 2015
Fire and Safety Inspection: Yes — Date of Last Inspection: Oct 2014
Fire Suppression Inspection: Yes — Date of Last Inspection: Aug 2015

Average Daily Population for the Preceding 36 month period: 1,556
Average length of stay for the proceeding 36 month period: SEE ATTACHED

Housing: a. Number of Beds: METRO JAIL-863 BARRACK'S-328
b. Single Occupancy Cells: METRO JAIL-5 BARRACK'S-0
c. Multiple Occupancy Cells: METRO JAIL-858 BARRACK'S-328
d. Number of Dormitories: METRO JAIL-0 BARRACK'S-8

Date facility was constructed: 1984 PLEASE SEE ATTACHED (BUILD IN PHASES)

Date of last renovation: SEPTEMBER 2014; GED CLASSROOM

Total number of admissions and release for the last three years:

Provide information on issues the current administration would like to address by a physical facility operations review: *Intake / Docket Too Small. Clinic Too Small; Not enough segregated housing, inadequate special housing.*

Are there any plans for new construction? Yes No
If yes, please detail: Discussions are on-going.

Current Inmate Profiles:
Average Age: SEE ATTACHED
Race: SEE ATTACHED
Sex: SEE ATTACHED

Percentage of Current Inmate Charges vs Total Population:

Traffic: SEE ATTACHED
Misdemeanor: SEE ATTACHED
Felony Violent: SEE ATTACHED
Felony nonviolent: SEE ATTACHED

Percentage of Current Inmate Status vs Total Population per Day:
Pretrial: SEE ATTACHED
Presentence: SEE ATTACHED
Sentenced: SEE ATTACHED

Provide the number and type of critical incidents within the last 36 months:

2012, Number: 1 Types: JAMES VINSON NIX-IN CUSTODY DEATH

2013, Number: 0 Types: NO CRITICAL INCIDENTS DURING THIS YEAR

2014, Number: 1 Types: FRANK CHARLES POVVELL-IN CUSTODY DEATH

Provide the number of Inmate disciplinaries within the last 12 months:

Minor Disciplinaries: 1 401
Major Disciplinaries: 371

Provide the number of inmate grievances and types within the last 12 months.

100 / 120 Commissary, Medical, Sanitary, Showers, Plumbing

Describe any gang issues related to jail operations as it relates to this project: NA

2012:Admissions:	29,271	Releases:	28,727
2013:Admissions:	27,624	Releases:	27,259
2014:Admissions:	23,704	Releases:	23,326

If yes, please detail: _____

Facility Staff:	MALE	FEMALE
Certified Staff	69	112
Medical Staff	8	48
Non-Certified	13	48
TOTALS	157	247
Volunteers	67	39

Some of the observations and findings herein may be repeated throughout the report as applicable to specified areas.

A. **Sally Port**: The entire area is inadequate in physical size given the number of arrests coming through the docket daily, particularly during busy times. The sally-port is cramped and can only handle a few law enforcement vehicles at a time. The perimeter of the sally-port is unsecured without public barriers, allowing the public to approach either end of the drive through the sally-port, which jeopardizes officer and public safety. Outside gun lockers used by arresting officers are insufficient in number and broken. Only one locker

had a working key. Officers to have to secure their weapon in their car or leave in it in the car, which is extremely dangerous, as noted in a previous incident that occurred in the sally-port when an arrestee overpowered the arresting officer, took his gun, fatally shot him and proceeded to drive away through the sally-port doors.

B. **Initial Intake Area**: The transfer of custody from the arresting officer to the Metro Jail staff takes place in the intake area. There are two doors; one inner door and one outer door plus the two roll up sally-port doors. None of these doors are inter-locked which lends itself to the possibility of escape or mix of inmates that should be separated. This area is inefficient for the arresting officer to conduct searches *(see Illinois v. Lafayette, 462 U.S. 640, 645 (1983))* and do necessary paperwork *(see for example Mann v. Taser International Inc, 588 F.3rd 1291 (11th Cir. 2009))*. It is extremely small and very hard to accommodate more than one arrestee at a time, producing a backup with arrestees being admitted into the facility. This causes great delays in deputies, police officers and other arresting agencies in returning to their patrol areas in the Metro area. During the two day verification assessment, this issue was observed as the norm rather than the exception. Both correctional and law enforcement officers when interviewed expressed frustration and concerns of safety and inefficiencies because of the tight quarters. There are two small holding cells located in the initial intake area. Both have blind spots making it difficult for staff to observe individuals placed in the cells. This presents a high liability risk for those being admitted with suicide ideation *(see generally Farmer v. Brennan, 511 U.S. 825 (1994); ALA. CODE § 14-6-105)*. The cell on the far side allows the arrestee the ability to stand up on the bench in the cell and peer into the docket/processing area with views of computers and other confidential information.

C. **Docket/Processing**: Once the initial intake screening of newly admitted arrestees is performed in the small intake area, then the arrestee is brought into the docket area for additional processing. There is no privacy for staff in the docket/intake area – everything is viewable by inmates being processed as well as those in the holding cells. There are two gang/group type holding cells: one for males and one for females. Both are small given the number of arrestees admitted to the jail and at times appear to exceed standard fire code occupancy capacities. When the desired capacity is exceeded, the jail risks compromising safety, security, order, discipline, ensuring adequate health care, food service, sanitation, exercise, or other essential inmate services *(see Rhodes v. Chapman, 452 U.S. 337, 347 (1981))*. Additionally, potential inmate-on-inmate violence may occur, which could bring

the county into potential liability risks *(see Rhodes v. Chapman, 452 U.S. 337, 350 (1981)).*

Inmates being released can easily communicate/sign with females due to the physical layout with limited separation between the female docket holding cells and release. There also is not additional space to separate arrestees. When multiple arrestees are introduced to this area, alternatives are not readily available to have co-defendants, known security threats, arrestees with infectious diseases, rival gang members, those at risk to sexual abuse/assault, or just enemies separated. This greatly increases the liability and the failure to protect inmates from known acts of violence or the potential thereof *(see Farmer v. Brennan, 511 U.S. 825 (1994); 28 CFR § 115.6. (PREA); US Constitution 8th, 14th Amendment).* There are additional holding cells down the hall away from the docket area, which the staff refers to as "Mardi Gras" holding. These holding cell areas are currently being used to store inmate property and as a staging area for inmates being transferred to the Department of Corrections. The location, general design of the cells and the lack of adequate staff necessary to view and supervise inmates being placed in these holding cells makes the use of them for inmate holding very inefficient, costly and may present safety, security and liability issues due to the inability to properly supervise.

D. **Unnecessary Delays in Release**: When the city of Mobile brings in someone under arrest the Metro jail staff has to contact the city to check for outstanding warrants prior to being able to release the arrestee. This process is often delayed – up to two hours. The automated jail management system and the city of Mobile's warrant verification systems are not compatible. This requires the metro jail to hold inmates longer to post bond. This could create additional liability to the Metro jail system if the inmates are delayed unnecessarily *(see generally ALA. Code §15).*

E. **Special Inmate Housing**: Several areas do not comply with current ADA standards as explained in the Americans with Disabilities Act *(see generally 42 U.S.C. sec. 12101, et. seq. (ADA).*

1. Thresholds into shower areas prevent inmates confined to wheelchairs to be unable to enter the shower areas, or when able to enter the shower unable to have the assistance of a handicapped shower fixture, shower chairs, grab bars *(42 U.S.C. sec. 12101, et. seq.).*

2. There are also more handicapped inmates than the number of ADA cells, which from information from Metro jail staff is also more the norm than the exception. This also increases the liability to Mobile County for failure to comply with American with Disabilities Act. *(42 U.S.C. sec. 12101, et. seq.)*

3. Mental Wedge (H) given the suicide risks, there are no nightlights in the cells. Making it difficult if not impossible for staff to properly supervise this high risk area *(see Cagle v. Sutherland, 334 F.3d 980 (11th Cir. 2003)).*

4. Juvenile Unit (B) houses 24 youthful offenders but was averaging 8-10 ADP which is lots of wasted space, especially given the apparent staffing issues.

F. **The Medical Unit (Clinic):** While the operations of this area are outsourced outside of the Metro Jail management, there are potential issues as related to the physical layout and conditions that are noted as follows:

1. There is no staging area for inmates being seen in the clinic which creates a bottle neck and mixing classifications of inmates.

2. Exam room where medical staff sees inmate patients has no sound barrier between the exam room and an actual medical cell. This makes it difficult for medical staff to discuss an inmate's medical condition without other inmates overhearing confidential conversations between the medical professional and the inmate being treated. Increased liability exists if this is not corrected *(see Health Insurance Portability and Accountability Law; 45 CFR 164.512(k)).*

3. The number of inpatient medical beds in the clinic for inmates that are required to be housed in the clinic are very limited and very often forced to be housed in other housing within the jail facility. This could produce potential liability associated with adequate medical care *(Estelle v. Gamble, 429 U.S. 1066 (1976)).*

4. The sight lines within the clinic prohibit the medical staff and jail medical officers from maintaining continuous supervision over the inmates housed within the clinic, which may compromise safety, security and timely response to potential incidents of inmate-on-officer and inmate-on-inmate assaults *(see Farmer v. Brennan, 511 U.S. 825 (1994); US Constitution 8th, 14th Amendment).*

5. A number of inmates suffering from some form of mental illness are not able to be segregated from other medical needs inmates and at times are forced to be housed

together with other special needs inmates. Increased liability and inefficient operations of the medical facility are due to these issues *(Youngberg v. Romeo, 457 U.S. 307, 323 (1982).*

6. There are no negative pressure rooms in the clinic so any inmates with positive TB test cannot be segregated from other inmates or staff thus creating possible exposure to other inmates and staff. This may create potential safety and liability issues with inmates and staff *(Hudson v. Palmer, 468 U..S. 517, 526-527 (1984); Florence v. Board of Chosen Freeholders of Burlington County, 132 S.Ct. 1510 (2012); ALA. CODE § 14-6-95).*

7. A lack of medical staff bathroom facilities inside the medical clinic unit requires staff to leave the unit to visit restrooms. This inefficiency increases the time the medical staff is away from the clinic.

8. Pharmacy is maxed with limited space to operate for a jail population this size.

9. There appears to be a limited amount of showers built within the medical unit for inmates' use *(see generally Alabama Code § 14-6-94).*

10. Limited treatment rooms for (EKGs, X-ray, etc.). There are no rooms for staff to work privately without inmates right in front of them. Inadvertent confidentiality violations with HIPPA may occur because of the physical room constraints *(see generally HIPPA /Health Insurance Portability and Accountability Law; 45 CFR 164.512(k))..*

11. Need for more direct observation cells to better observe inmates that are pregnant, have infectious disease, need to be quarantined, or simply have major medical issues *(see for example Coleman v. Rahija, 114 F.3d 778, 786 (CA8 1997); ALA. CODE § 14-6-95).*

G. **General Population Housing Units**: The Metro Jail is aged and outdated in technology. The housing units were not built at one time but gradually as an increase in population created a need for increased beds. This increases inmate and staff movement to utilize necessary inmate support areas, such as kitchen, education and treatment programs, laundry, and religious services. Inmate movement, especially given the physical constraints and layout of the housing units, increases risk of assaults and escapes and increases the need for additional security staff, even if the inmate population is lower. There are some additional concerns related to the physical facility of the housing areas:

1. Many of the general population housing units were originally designed where the inmates have control of their cell lights. It was observed by inspectors that many times the jail officers could not see any activity that may be going on within the cell. Officers cannot tell if there are more than one inmate, if the inmate is violating jail rules, attempting suicide, assaulting another inmate or being housed in that cell *(Hoptowit v. Spellman, 753 F.2d 779 (CA9 1985*). This makes it very difficult for the jail staff to carry out their duty to protect *(see Farmer v. Brennan, 511 U.S. 825 (1994); US Constitution 8th, 14th Amendment)* and may increase liability to the Metro Jail.

2. Due to the large number of special needs inmates being housed in general population creates a greater risk of violence to these inmates and makes proper classification a very difficult task *(see generally Alabama Code 20-602; Hudson v. Palmer, 468 U..S. 517, 526-527 (1984).*

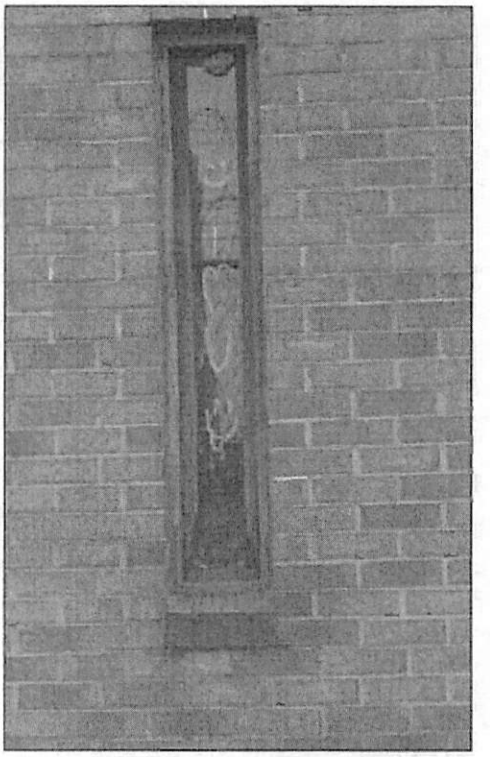
H. **Minimum Custody Barracks:** This facility is the most modern of any of the Metro Jail buildings, located across the street from the main jail, and is in good physical condition.

1. One of the floors was not in use and one of the large rooms on the first floor could be better utilized for other duties and tasks.

2. The barracks lack some security measures to be considered to house certain classification levels of inmates who would not be best placed in a larger dormitory style housing area *(ALA. CODE § 14-6-103 "Adequacy of Jail.")*. The shower areas have bad sight lines making the supervision of inmates difficult and more staff intensive to monitor, particularly with the lack of CCTV available in those areas *(see Farmer v. Brennan, 511 U.S. 825 (1994); US Constitution 8th, 14th Amendment)*. Staffing deficiencies were identified in the barracks that pose a potential threat to

officer and inmate safety in response to assaults or escapes *(see Hamilton v. Covington, 445 F.Supp. 195, 202-203 (W.D. Ark. 1978).*

I. **Female Housing Units**: The female housing units have individual cell windows on the east side of the jail facility that has a public side street that runs parallel to the building. The inmates can be seen from passers and communication between the public and the female inmates was observed. Inmates had placed their names and messages in the windows so that the public could tell exactly which cell they were in.



Evidence of balloons, posters and other personal items were apparent, acknowledging public's access to this street to communicate with the female population *(see picture)*.

Jails, by their very nature, must be tightly controlled. The unauthorized communication between public and inmates may lead to possible escapes, assaults, witness and case tampering, and other adverse events.

J. **Disciplinary Male Housing Units**. Segregation cells are used as an effective management tool to assist with disciplinary infractions by inmates.

1. Over the past several months there has been an increase in inmate-on-officer assaults coming from this classification of housing. There are very limited segregation cells available to meet the current need for inmates that need to be isolated due to disciplinary and behavior management issues. Not enough of these type cells meet that type of classification. This jeopardizes the safety of inmates and officers. Furthermore, it may encourage inmates to continue to disregard jail rules and regulations knowing there is an unlikely chance of movement following behavior that would usually result in disciplinary measures *(see Turner v. Safley, 482 U.S. 78 (1987)).*

2. The need for increased staffing in the disciplinary housing is evident. Staff reported a lack of confidence and ability in responding to incidents. Cadets were placed in the area but by policy they are not allowed to be involved in inmate interaction, which does not provide needed assistance when altercations and incidents require it.

K. **Central Control**: Central Control is responsible for the control of movement throughout the facility as well as video monitoring of key areas in the facility.

1. This surveillance system has a history of going down, making the monitoring of certain areas impossible. Jail staff stated that this happens on a regular basis. One inspector witnessed during the 2 days and nights present Camera #46 (sally port entrance camera) was blacked out at one point but reappeared later. Staff could not explain why but said it was common. County security electronics staff stated that they are currently working to correct this problem with a vendor.

2. There are no redundant work stations to allow for continuous monitoring, particularly whenever a unit goes down. This creates security concerns affecting both inmates and staff. There are 400-500 cameras reported to exist throughout the facility that must be monitored by central control. Many of the cameras are PTZ cameras that are set to be on a constant rotation. This makes it difficult to record, view, and monitor an entire incident. Recording is recommending because it provides the Jail the ability to verify staff and inmate actions and provide evidence, especially when dealing with incidents associated with inmate-filed lawsuits.

3. Emergency shutoff valves are not functioning. According to maintenance that was present during the onsite, the control panel was "fried" and could not be repaired without significant cost. Ignoring the repairs could produce serious liability and safety risks *(see Escambia County - Pensacola, Florida, where previous water damage in the jail due to flooding resulted in a fiery gas explosion in 2014, resulting in two deaths and dozens hurt).*

4. Sprinkler heads break and the Simplex system reads out the wrong location. For example, it may read 1202 but the cell unit really is 1005 or 1002. The modules are only known to maintenance, which if needed after hours, is difficult to respond before considerable flooding or water damage could occur. This could become a costly repair for the county if ignored.

L. **Visitation Area**: The visitation area for a facility this size is grossly undersize, located away from general population housing and very staff intensive to operate.

1. Access to visitation area is not securely controlled access meaning that visitors can walk right into visitation. This is extremely dangerous to both staff as well as other visitors. *(On Sept 4, 2015, an arrestee escaped from the sally port of Sumner, TN Jail, took the officer's gun and ran into a non-secured visitation area taking 30 hostages. Fortunately, he was eventually overpowered without serious injuries to the public and fellow officers).*

2. There are no cameras placed in the visitation area to be used as a surveillance tool for staff to monitor inmates or public visitors. A lack of observation may allow visitors to potentially provide inmates with contraband *(see Westchester County, NY where visiting wife passed synthetic marijuana to her incarcerated husband. He shared the drugs with other inmates who all became sick, costing the County tens of thousands of dollars in medical fees and staffing)*. It also may allow inmates and visitors to engage in prohibited sexual activity, violate jail rules, allow access for inmates to attack visitors *(such as cases where inmate was visited by wife and girlfriend at the same time, resulting in assaults between inmates and/or visitors)* with limited staff response time.

3. Attorney visitation rooms are limited in quantity and not enough to support the current inmate population.

4. There is not a designated staff post for distant observation between attorneys and inmates (to prevent and respond to occurrences as needed) nor are there cameras currently employed. A lack of observation may allow attorneys to potentially provide inmates with contraband or violate jail rules, such as sexual contact *(see for example, McMaster v. Pung, 984 F.2d 948 (8th Cir. 1993); Rhode Island Defense Attorneys' Association v. Dodd, 463 A.2d 1370 (R.I. 1983); State v. Staab, 430 So.2d 1370 (R.I. 1983)*. Additionally, duress buttons are the only means for attorneys to notify staff of an assault or situation. These presents a legitimate safety issue and potential liability risk.

M. **Kitchen:** The kitchen is operated under contract but security responsibilities are maintained by the Metro Jail.

1. The kitchen appears to have no established hours of operation and appeared to be open 24/7 with open access.

2. The way the kitchen is physically constructed allows for multiple ingress and egress points (multiple loading docks, entrances to the kitchen areas, etc.), potentially compromising safety and security without controlled points.

3. The HVAC units that service this area seem to need regular replacing or repair. Reports of the A/C not working appear according to logbooks are frequent *(see ALA. Code § 14-6-103 "Adequacy of Jail.")*. This may be, in part, due to the age of the kitchen and its equipment.

4. The dishwasher according to inmate workers and food service staff is constantly going down, causing delays in getting the trays washed and ready for the next meal *(see US Constitution Eighth Amendment)*

5. The drain/trash compactor is currently broken. This may be, in part, due to the age of the kitchen and its equipment.

6. The security staffing for the kitchen is grossly inadequate for the number of inmates working in this area together, especially combined with the horrible sight lines. It appears security staffing is supplemented, perhaps unintentionally, by kitchen volunteers, who are not trained and do not have security minded objectives. This may increase liability in the event of incidents in the kitchen area *(see Farmer v. Brennan, 511 U.S. 825 (1994); US Constitution 8th, 14th Amendment)*.

7. Tray carts often are tipped over or fall, mainly due to the physical design and layout of this area. The trays are held in place by a rope that is tied to the cart.

8. The kitchen equipment itself is dated and many items need to be replaced or additional items added. This causes slow meal preparation and often causes meals be delayed.

N. <u>Support Areas</u> (Laundry, Supply, Classroom, Mail)

1. The supply area space is small given the inmate population and capacity. Many items, such as mattresses, inmate personal hygiene supplies, chemicals and other items. Inventory is difficult to manage with storage in multiple locations, including unlocked closets and other areas. This also presents potential issues ensuring the other areas are secure so that chemicals, for example, are not accessible by

unauthorized inmates for purposes other than intended (potentially used as poison or an implement of suicide – *see generally Rhodes v. Chapman, 452 U.S. 337, 364 (1981)).* A shortage of space causes items to have to be ordered in limitation rather than capitalizing on order of magnitude pricing. The supply area has a code access control but it was apparent that many of the staff know a master code, which allows them to gain entry. This area also is operated by a single staff person. Singular staff operations limit the efficiencies of the operation that happen in this area and could become a management headache if that individual was not available for extended periods of time or ever ceased employment.

2. Laundry area appeared to be adequate in size but the supervision of inmate workers is very limited. Increased liability is evident here and duty to protect is questionable. During the field visit, staff was present only one time at the laundry area during the six visits there *(see Farmer v. Brennan, 511 U.S. 825 (1994); US Constitution 8th, 14th Amendment).*

3. Classroom/Education/Religion programming seems to be the strongest area of emphasis and resources for the jail, evident by the existence and use of the chapel, allocated classroom space, etc. Programming influence is felt throughout the facility and extends to the housing units on posters, announcements, and daily scheduling. However, the location of these programming areas in relation to housing units, coupled with limited cameras/surveillance provided in these areas may produce a safety and security risk *(see Farmer v. Brennan, 511 U.S. 825 (1994); US Constitution 8th, 14th Amendment).*

O. **Maintenance.** A facility this size requires constant preventative and ongoing maintenance and repair. The current work order system in place is very cumbersome and the ability to track when a work order has been completed is difficult at best. In every area of the facility there appeared to be some type of maintenance issue, many of which are caused by the aging conditions of the jail over the years. Jail staff stated that the maintenance staff there worked hard but was basically impossible to ever "catch-up" on the ever-growing work order list. For a facility this size to not have designated maintenance staff working directly for the jail system is not the norm. Plumbing is often a major issue with inmate filed lawsuits pertaining to conditions of confinement and seemed to be a main problem throughout the facility and, in talking with maintenance staff, will not ever be resolved without substantial financial investment and cost. Adequate sanitary plumbing and

sewage connections are also a required condition by state statute *(see ALA. CODE § 14-6-103 "Adequacy of Jail.")*

RECOMMENDATIONS

The following recommendations, suggestions and ideas are provided as an inclusion in this project and scope of work by NIJO. It should be noted as part of the scope of this project that NIJO was asked to consider needs as part of a remodel rather than the creation of a new jail. Furthermore, these recommendations are the opinion of NIJO, may not reflect those of Mobile County or the Sheriff's Office and may not be listed or prioritized as such.

A. **New Comprehensive Sally Port – Intake and Docket/Booking Area.**

1. The most immediate needed area to be replaced is the docket/intake/sally port/booking area. This area is beyond expanding or renovating to correct the issues. A replacement building that addresses all of the concerns and findings noted previously is suggested.

2. The sally port needs to be sized to accommodate a bus or emergency vehicle. It should allow for multiple patrol cars to enter and park within this area. It should be designed so that arresting agencies enter a gated, secure area prior to the actual sally port drive in. This will correct the security concerns. Adequate lighting and camera placement should be considered as well.

3. An arrestee processing (pre-admission) area is recommended to be placed between the sally port and the actual intake area. This area will allow arresting agencies to process the arrestee, check for warrants, intoxolizer and fingerprint functions, gather and produce all needed paperwork at a secure location prior to turning over to the jail intake. This area should have holding cells to be able to separate multiple arrestees and provide areas to conduct searches *(see E.g., Ferraro v. United States, 590 F.2d 335 (CA6 1978); United States v. Park, 521 F.2d 1381, 1382 (CA9 1975); see also Florence v. Board of Chosen Freeholders of Burlington County, 132 S.Ct. 1510 (2012)).*

4. The actual booking area will need to accommodate multiple holding cells for various classifications of offenders. Normally in a facility this size, this area will also include a couple of "safe-cells" for arrestees that are overly combative, have mental health issues, are transgender and should be housed separately for protection against other inmates, have suicide ideation, are at-risk juveniles, are known gang members and a threat to others in the same holding area, or to separate eye witnesses in a particular case *(See generally Farmer v. Brennan, 511 U.S. 825 (1994); 28 CFR § 115.6. (PREA); US Constitution 8th, 14th Amendment).* The area should also have separate holding areas for females that preferably cannot be seen by male offenders *(ALA. CODE § 14-6-13 -" Separation of men and women".).* Finally, the area should accommodate the need to conduct searches in a private manner, including strip searches, as needed.

5. The proposed building should also incorporate magistrate access, secure bondsman access, and an initial medical triage area for initial assessment on newly admitted inmates.

6. An adequately sized inmate property storage area, which can accommodate both inmate personal property as well as jail issued clothing and supplies for newly admitted inmates, should also be included in the building. This property storage should include an accountable inventory system (bar code, efficient storage and retrieval, etc.) in order to maintain control over these items *(see Illinois v. Lafayette, 462 U.S. 640, 646 (1983)).*

B. **Build a Special Needs Housing Unit.**

1. NIJO recommends the creation and building of a new Special Needs inmate housing unit which would include medical, suicidal, transgender, and all special needs inmates. Juveniles housed at the jail could also be housed in this area. The size of this unit (number of beds/capacity) would depend on findings from a detailed special needs population projection study. Options to consider include the implementation of a multi-story unit with the "clinic" for the entire jail system housed on the lower floor, with special needs and other medical or mental health inmates housed near the clinic to allow for prompt and efficient operations.

2. The clinic should address all the deficiencies listed in the field report findings, such as pharmacy size, exam rooms, treatment rooms, staff restrooms, sight-lines, separation of male and female, mental health, etc.

3. An emergency vehicle sally port should be considered as part of this unit to allow for pick up and transport directly from this Special Needs building. This feature will minimize liability simply by reducing the time required to get inmates out of the building during emergency situations.

C. **Address American With Disabilities Act Issues.**

1. There were numerous ADA concerns noted in the field report section. It is recommended that they all be addressed as soon as possible (*see generally 42 U.S.C. sec. 12101, et. seq. (ADA)*. The proposed Special Needs Unit above would certainly assist with this need.

2. Take corrective action on deficiencies noted.

D. **Conduct a Staffing Analysis.**

1. Determine if the facility is sufficiently staffed to handle the existing workload to address safety and security concerns. It was evident that more staff is needed to address many of the concerns noted, many of which appear to be caused by physical facility layout and design.

2. Should new construction be decided, the staffing analysis can be used as a baseline to determine staff needs (and operational costs) of any proposed jail design.

E. **Address the Current Visitation Area Access and Security Issues.**

1. There were issues revolving around observation, safety and security noted in the onsite findings with the visitation area relating to the physical facility. It is recommended that they all be addressed and corrective action taken with deficiencies.

2. Solicit advice from a source familiar with American with Disability Act requirements to assist in determining how to meet those needs as it relates to visitors, attorneys and inmates.

3. Consider options using vendors to provide video visitation. This option is easily implemented, reduces inmate movement, reduces the introduction of contraband and saves the staff considerable time and jail administrative costs.

F. **General Population Housing.**

1. Correct the lighting issues in almost every housing area. Eliminate the inmates from having the ability to control their lights. This is a huge issue and makes it almost impossible for the staff to view, supervise and monitor the activities of inmates happening within the cells *(see Hoptowit v. Spellman, 753 F.2d 779 (CA9 1985))*. It may be helpful to hire an electrical engineer to address these issues if the County does not have solutions.

2. Develop a detailed punch list by priority to repair, replace, and upgrade, etc. all maintenance issues *(see generally Rhodes v. Chapman, 452 U.S. 337, 348 (1981))*.

3. Implement a weekly safety, security, and maintenance inspection. Document all findings and take corrective action *(see ALA. CODE § 14-6- Article 4 "Inspection of Jails and Sanitation Requirements")*.

4. Fix the Female housing windows. NIJO recommends contracting with a window tint company to apply mirrored tint to the exterior of the windows, not just in the female housing but also in all housing where the public can look into the housing unit windows from the street. This would eliminate the public from communicating with the inmate population and would increase the security significantly without a great expense.

5. Remove exterior signs that identify the specific buildings. This information can be used by the public to identify the location of inmates, a potential security and safety risk to officers, inmates and public.

G. **Develop an Enhanced Classification System.**

1. Design and implement an enhanced inmate classification system and formal inmate housing plan to ensure appropriate separation of various classes of inmates *(see Turner v. Safley, 482 U.S. 78 (1987); See generally Bell v. Wolfish, 441 U.S. 520, 548 (1979) and O'Lone v. Estate of Shabazz, 482 U.S. 342, 353 (1987))*.

2. NIJO recommends the consideration of adding a classification unit of approximately 64 beds to be used for newly admitted inmates. Staff can observe behavior and better make classification assignments. Such a unit would be especially useful during weekends and holidays when classification staff may not be available rather than placing them in general population immediately.

H. **Inmate Identification System.**

1. Currently the jail is using an inmate ID system that consist of an ID card that they are required to have on them at all times. The ID cards are not visible to staff and difficult to read from more than a few feet away. Many ID cards were broken, had missing clips, or simply the inmate did not have it with them. This is consuming valuable staff time attempting to identify these inmates. NIJO recommends implementing an inmate wrist band system that is issued during intake and is worn until release. This option could save an already short staff valuable time, as well as savings as wristbands are generally less expensive than issuing ID cards.

2. Make inmates more accountable if inmate identification is not presented. Develop an inmate disciplinary system that has sanctions for infractions or violations of jail rules. Having more disciplinary segregation cells and using them would benefit officers and inmates, to uphold jail rules and not become indifferent with no significant consequences *(see Turner v. Safley, 482 U.S. 78 (1987))*.

I. **Video Visitation and Video Arraignment:**

1. NIJO recommend implementing a video visitation system. This would:
    a. eliminate extra movement of inmates; and
    b. reduce the introduction of contraband into the facility by visitors.

2. Investigate and consider the use of video arraignment to minimize the transports from the jail to the courts:

a. The barracks has space on the first floor that could be used for the public side of the video visitation. Administrators can establish a check-in station in the front lobby of the barracks to facilitate this process. This alone would result in the reduction of contraband, inmate assaults and possible escape attempts.

b. Implementing video arraignment is relatively very inexpensive, especially given the cost of staffing and transporting a large number of inmates to the courthouse daily. Limited renovation and dollars would be needed to accomplish this. The current security electronics provider can assist with this addition.

c. It appeared during the onsite verification that there was already video arraignment equipment installed in some of the courtrooms.

J. **Court Security.**

Please note there was limited observation given the time constraints of the onsite and primary focus of the jail's physical facility.

1. With 12 courtrooms, 1 Sgt., 1 Corporal and 10 officers, it lends itself to great liability for correction staff to be responsible for safety of the courtrooms with they are unarmed and have no power of arrest.

2. Radios for transmission and contact throughout the facility between officers do not work in many areas, which is a safety and security concern.

3. Holding cells need to be staffed better to properly observe and provide for protection of inmates and the public. It seems like targeted areas such as transportation and booking are tapped quickly in the event of staff shortages, leaving those areas even more at risk.

K. **Increase the Frequency of Staff and Inmate Interaction.**

Due to physical layout of the facility, spread out conditions, current average daily population and capacity, it is recommend more frequent staff and inmate interaction to discover, prevent, detect and respond to situations, reduce tension and potentiality for violence in housing and support areas. This can be effectively accomplished with increased staff on shifts and proper staff training.

L. **Conduct a Physical Plant Feasibility Study Assessment.**
If recommendations to build the Sally Port-Intake-Booking area, Special Needs Unit and Classification Unit are going to be enacted, a Request for Proposal (RFP) should include the following:

1. Site evaluation(s);
2. Schematic drawing development; and
3. Cost estimates

SUMMARY

The **United States Supreme Court** and **Alabama State Code** provide the Sheriff the authority and responsibility of the jail, declaring "the sheriff has the legal custody and charge of the jail in his county and all prisoners committed thereto." **Alabama Code § 14-6-1.**

The on-site inspection provided an outside verification and independent review of the overall physical layout and design, construction, emergency conditions, safety and security, recent inspections, sanitation and maintenance, facility access, health care and medical, inmate services to include laundry, cleaning, culinary, religious and educational/treatment programming, and inmate housing areas.

During the on-site inspection, it became clear the facility has numerous physical challenges and limitations for which the jail administration are aware of and are seeking assistance to correct as it relates to the above areas of operation and management. The facility layout is outdated, cumbersome and staff intensive to operate. The current staffing level is not sufficient to run the facility within constitutional guidelines, especially given the physical layout. Likely out of necessity and shortages in available officers, skeleton staffing seems to be the norm for each shift. The administration faces significant hiring and retention issues. Because of turnover, the average floor officer has limited experience and many do not last long as career correctional officers, despite the efforts of the administration to retain them and create a positive work environment.

It is apparent that the Sheriff and local government officials are aware of the many issues described in this report. The jail staff desires to do the right thing but is restricted from doing so for several reasons, often related to available financial resources and budget.

When discussing adequate facility design and staffing, it should be clear there are no constitutional, 11th Circuit Court or state laws from Alabama that provide specific legal requirements to measure outright "compliance." Courts have repeatedly recognized the importance of providing a safe and secure environment and adequate staff to perform necessary duties and provide for the safety and security of the inmates; however, they also recognize the variety of physical structures, technology, inmate classification types, and other factors which make comparing one facility's staffing to another impractical and ineffective. Courts have therefore focused on having basic human needs and proper staffing to protect inmate rights, such as access to medical *care (8th Amendment; **Estelle v. Gamble**, 429 U.S. 97 (1976))*, religion *(1st Amendment, **RLUIPA, O'Lone v. Shabazz**, 482 U.S. 342, 348 (1987))*, courts and counsel *(14th Amendment; **Lewis v. Casey**, 518 U.S. 343 (1996))*, communication *(1st Amendment; **Thornburgh v. Abbott**, 490 U.S. 401, 415 (1989))* , exercise *(**Wilson v. Seiter**, 501 U.S. 294, 304-305 (1991))*, food *(1st Amendment; **Rhodes v. Chapman**, 452 U.S. 337, 356, 364 (1981))*, the duty to protect against physical harm and sexual assaults *(8th Amendment; **PREA, Farmer v. Brennan**, 511 U.S. 825 (1994))* and so forth.

PHYSICAL FACILITY

As it relates to the primary scope of this project, the physical facility was evaluated by NIJO, an independent, third party. According to **Alabama Code § 14-6-103** "Adequacy of Jail" the jail as a physical structure must comply with specific requirements governing the custody and conditions of confinement of inmates.

> *"Each county jail or town or city prison must be of sufficient size and strength to contain and keep securely the prisoners confined therein and must contain separate apartments for men and for women. It shall be fireproof, properly ventilated, sufficiently lighted by day and night, adequately heated and contain adequate sanitary plumbing and sewerage connections."*

As indicated, the main reason is the physical constraints of the building. While it would be perhaps advantageous in the long term to consider the procurement of a new jail in a different location away from flood zones, highway and public street access, and an anticipated increased inmate population in the future, the facts are that option is an unlikely possibility considering limited funding sources. Consideration for a remodel to the existing facility appears to be the next best option available.

Farmer v. Brennan, 511 U.S. 825 (1994), was a case in which the Supreme Court of the United States ruled that a prison official's "deliberate indifference" to a substantial risk of serious harm to an inmate violates the cruel and unusual punishment clause of the Eighth Amendment.

Justice Blackmun's concurring opinion went further, saying that the government was responsible for the conditions inside even if no specific agent of the government had acted in a particularly culpable manner.

> *Where a legislature refuses to fund a prison adequately, the resulting barbaric conditions should not be immune from constitutional scrutiny simply because no prison official acted culpably. [...] The responsibility for subminimum conditions in any prison inevitably is diffused, and often borne at least in part, by the legislature. Yet, regardless of what state actor or institution caused the harm and with what intent, the experience of the inmate is the same. A punishment is simply no less cruel or unusual because its harm is unintended. In view of this obvious fact, there is no reason to believe that, in adopting the Eighth Amendment, the Framers intended to prohibit cruel and unusual punishments only when they were inflicted intentionally.*

Jails represent one of the largest liabilities for county government. With the attention from the US Congress, new legislation, such as the **Prison Rape Elimination Act** , and recent US Supreme Court cases such as **Holt v Hobbs** prove jails are at the forefront of the public and liability eye. Every attention should be given by county officials to work to effectively run constitutionally safe jails and thus reduce potential liability. While it may not be popular by some, these efforts are required by law and can save taxpayers hundreds of thousands of dollars. Most importantly it can very likely save lives and protect those that work in the jail and those who are incarcerated.

Related to the physical facility, NIJO especially encourages attention to the sally port, intake, booking, and docket area. The unsecured, cramped, inadequate, understaffed conditions should be addressed as soon as possible. There is at least three locations on the jail premises that would allow for expansion and building of this unit and the others recommended in this report.

STAFFING ISSUES

During the exit interview, the staff was in agreement with the findings in this report. The administration and staff was generally eager to assist in attempting to find a way to make the facility a safer and more secure place to work. Staffing, retention and hiring was of major concern to them and NIJO. Any efforts and recommendations as contained in this report to address those concerns would be appreciated, needed and noticeable by both staff and inmates.

The Courts in **Farmer v. Brennan** state administrators must "ensure that inmates receive adequate food, clothing, shelter and medical care, and **must take reasonable measures to guarantee the safety of the inmates.'"**

In federal civil rights cases alleging failure to protect, the Supreme Court set the standard for liability as **deliberate indifference.** To be deliberately indifferent it is necessary to have had **actual knowledge of a substantial or excessive risk to a prisoner's health or safety and then disregard that risk.**

1. To have **actual knowledge,** individual defendants would have to have been **aware of facts** from which **an inference of an excessive risk could have been drawn.**
2. Then, having considered those facts, **actually made the inference** that there was an excessive risk to the prisoner.
3. Without that actual knowledge the acts or omissions can rise to the level of deliberate indifference.

While conducting this physical facility analysis, the ability for inmates to exercise those constitutional rights was observed in relation to staffing. NIJO has applied many United State Supreme Court decisions to weigh in on this analysis and recommendations, primarily **Wilson v. Seiter,** 501 U.S. 294 (1991) and **Farmer v. Brennan,** 511 U.S. 825 (1994).

When inadequate staffing may contribute to any of these rights being violated, it becomes the focus and attention of the courts, particularly if there are documented occurrences caused by

limited staffing that an inmate's rights were in fact violated. These staffing issues may be even more enhanced when associated with the need for increased staffing, surveillance and observation is required because of the physical structure and layout of the jail.

FOR CONSIDERATION

Some organizations have attempted to define parameters by developing staffing, administrative and operational standards based on what they or outside organizations deem to be best. These are often called "best practices." Of such practices, the Supreme Court declared the following:

> *"[T]he District Court erred in assuming that opinions of experts as to desirable prison conditions suffice to establish contemporary standards of decency . . . . [S]uch opinions may be helpful and relevant with respect to some questions, but* ***'they simply do not establish the constitutional minima*** *. . . . Indeed, generalized opinions of experts* ***cannot weigh as heavily in determining contemporary standards of decency as 'the public attitude*** *toward a given* sanction."[1]

Later, the Department of Justice (DOJ) published *Federal Standards for Corrections*, intended to set the operational requirements for facilities that housed pretrial detainees (jails). When some courts began to reference and utilize the DOJ standards, the Supreme Court stepped in.

> *"[R]eliance on . . . correctional standards issued by various groups is misplaced . . . . And while the recommendations of these various groups may be instructive in certain cases,* ***they simply do not establish the constitutional minima****; rather,* ***they establish goals recommended by the organization in question.***[2]

The Supreme Court clearly defines for correctional facilities the importance of running a jail based on sound constitutional, legal-based principles rather than basing policies, procedure and operations on subjective practices not defensible in court.

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[1] **Rhodes v. Chapman**, 452 U.S. 337, 350 n.13 (1981). Also see **Gregg v. Georgia**, 428 U.S. 153, 173 (1976) (joint opinion).

[2] Among the standards listed by the U.S. Supreme Court as being improperly relied upon by the federal courts were the *Standards for Health Services in Correctional Institutions*; American Correctional Association, *Manual of Standards for Adult Correctional Institutions*; National Sheriffs' Association, *A Handbook on Jail Architecture*.

NIJO encourages Mobile County Sheriff's Office to rely on what the courts require and legal-based resources, to construct any proposed physical facility remodels and address deficiencies identified in this report, including staffing.

The inspection team, comprised of Todd Davis, CJE and Tate McCotter, CJE, wish to thank Sheriff Cochran, Warden Oliver, Deputy Warden Houston, the entire command staff at the Mobile Metro Jail, the Mobile County Engineering Department, Tyler Martin P.E., and all the Jail support staff including civilians that assisted in preparing requested documents, escorting and assisting the inspectors while onsite, and those who were interviewed. They were all professional, courteous and helpful in every way imaginable. Please accept sincere appreciation for the dedication and efforts to making this project be completed in a timely and effective manner.